

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30501

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

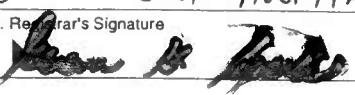
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department: If Item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Mary Louise Cornwell		09/05/2006				2:10 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Prince Georges Hospital		Cheverly				Prince Georges	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	II Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09/15/1905	9. Birthplace (State or Foreign Country) Tennessee
Usual Residence of Decedent						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State	10b. County	10c. City, Town or Location					
Maryland	Prince Georges	Bowie					
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?	
2809 Spangler Lane		20715				USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)					
William A. Vandergriff		Mamie Lee Neeley					
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
William P. Cornwell/ Son		2809 Spangler Lane Bowie, MD 20715					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Data		20c. Location - City or Town, State	
		Huntt Crematory		09/08/2006		Waldorf, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility		Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				Approximate Interval Between Onset and Death	
a. <u>FATAL CARDIAC ARRHYTHMIA</u> Due to (or as a consequence of):							
b. <u>MYOCARDIAL INFARCTION</u> Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29d. Date signed (Month, Day, Year)  058182 9-6-06	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		32. Registrar's Signature				31. Date filed (Month, Day, Year) SEP 08 2006	
DR. C. DONALD GEORGE						CHEVERLY, MD 20785	

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State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2006 30502

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marada Barbara Cowan Cargo</b>				2. Date of Death Month <b>Sept</b> Day <b>7</b> Year <b>2006</b>	3. Time of Death <b>8:45 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>4965 Mackall Road</b>		4b. City, Town, or Location of Death <b>St. Leonard</b>		4c. County of Death <b>Calvert</b>		
Funeral Director	5. Social Security Number <b>194-22-2274</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Aug. 26, 1928</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Calvert</b>		10c. City, Town or Location <b>St. Leonard</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>4965 Mackall Road</b>			10f. Zip Code <b>20685</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4</b> <b>Reading Aide</b>		16b. Kind of Business/Industry <b>Public School</b>		
	17. Father's Name (First, Middle, Last) <b>Donald Cowan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Cherrington</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Sharon Cargo (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4965 Mackall Road, St. Leonard, Maryland 20685</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Christ Episcopal Church Cem</b>		Date	20c. Location - City or Town, State <b>9/13/06 Port Republic, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rausch Funeral Home, P.A.</b>		22. Name and Address of Facility <b>4405 Broomes Island Road, Port Republic, Maryland 20676</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Congestive Heart Failure</b> Approximate Interval Between Onset and Death						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>Alzheimer's Disease</b> <b>Peripheral Vascular Disease</b>						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Alzheimer's Disease</b> <b>Peripheral Vascular Disease</b>						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 		29c. License number <b>D0052097</b>		29d. Date signed (Month, Day, Year) <b>9-7-2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>8096 Ventnor Rd., Pasadena, MD 21122</b>						
	31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>	32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial/transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

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State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

2006 30503

Certificate of Death

Reg. No.

1- For  
State  
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gladys Mary Creswell</b>							2. Date of Death Month Day Year <b>September 11 2006</b>	3. Time of Death <b>06 00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death				
Funeral Director	5. Social Security Number <b>219-16-8037</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>March 30, 1924</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Cecil</b>	10c. City, Town or Location <b>Port Deposit</b>						10g. Citizen of What Country? <b>U.S.A.</b>		
	10e. Street and Number <b>1464 Belvidere Road</b>			10f. Zip Code <b>21904</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>If Yes, Give Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Two Years</b>			16b. Kind of Business/Industry <b>Secretary</b>			16c. Location - City or Town, State <b>Fence Company Florida</b>		
17. Father's Name (First, Middle, Last) <b>Leroy Howard Kelly</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Mary Preston</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Mary Louise Burlin (Daughter)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1464 Belvidere Road, Port Deposit, Maryland 21904</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Hopewell Cemetery</b>					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hopewell Cemetery</b>		Date <b>09/14/06</b>	20c. Location - City or Town, State <b>Port Deposit, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Thomas M. Patterson, Jr.</b>					22. Name and Address of Facility <b>Lee A. Patterson &amp; Son Funeral Home, P.A. Perryville, Maryland 21903-0766</b>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death	
<p>a. <b>Congestive Heart failure</b> Due to (or as a consequence of):</p> <p>b. <b>Pulmonary Fibrosis</b> Due to (or as a consequence of):</p> <p>c. <b>Chronic Renal failure</b> Due to (or as a consequence of):</p> <p>d.</p>										<b>1 year</b>	
										<b>&gt; 5 years</b>	
										<b>&gt; 5 years</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death Check one or more <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number <b>AT 2438946</b>					29d. Date signed (Month, Day, Year) <b>September 11, 2006</b>	
29b. Signature and title of certifier <b>Quintina L. Benson, MD</b>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Quintina L. Benson, MD Union Memorial Hospital, Baltimore, MD</b>											
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>					32. Registrar's Signature <b>Quintina L. Benson, MD</b>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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State of Maryland / Department of Health and Mental Hygiene

2006 30504

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Angela Marie Carter</b>							2. Date of Death Month Day Year <b>9/18/2006</b>	3. Time of Death 5:56 AM			
	4a. Facility Name (If not institution, give street and number) <b>Prince Georges Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>			4c. County of Death <b>Prince Georges</b>				
Funeral Director	5. Social Security Number <b>213-94-3403</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>36 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>10/10/1969</b>	9. Birthplace (State or Foreign Country) <b>MD</b>				
	Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>			10d. Inside City Limits <b>Yes</b>				
To Be Completed by Funeral Director	10e. Street and Number <b>700 Toll House Avenue</b>				10f. Zip Code <b>21701</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Not Employed</b>			16b. Kind of Business/Industry <b>None</b>					
	17. Father's Name (First, Middle, Last) <b>Stephen S. Carter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Donna J. Morgan</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Stephen S. Carter Father</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4817 Mount Zion Road Frederick Maryland 21703</b>								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Smithsburg Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>			Date <b>9/19/2006</b>	20c. Location - City or Town, State <b>Smithsburg, Maryland</b>				
	21. Signature of Funeral Service Licensee <b>John O'Shea</b>			22. Name and Address of Facility <b>M01176 Keeney &amp; Basford P.A. F.H. 106 East Church Street Frederick, MD 21701</b>								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Arteriosclerotic Cardiovascular Disease</b>								Approximate Interval Between Onset and Death <b>Years</b>			
	<p>a. Due to (or as a consequence of): <b>Arteriosclerotic Cardiovascular Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) <b>9/19/2006</b>			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Respiratory Failure / Ventilator Dependent</b> <b>Peripneural Vascular Disease / End Stage Renal Disease / Right above knee amputation Diabetes</b>								23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29d. Date signed (Month, Day, Year) <b>18 September 2006</b>		
	29b. Signature and title of certifier <b>Paul A. Devore MD</b>			29c. License number <b>DO1852</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul A. Devore MD 4203 Queensbury Rd Hyattsville MD 20781</b>											
	31. Date filed (Month, Day, Year) <b>SEP 26 2006</b>			32. Registrar's Signature <b>Paul A. Devore</b>								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23aper Dr., G860, 10/05/06dhb State of Maryland / Department of Health and Mental Hygiene

2006 30505

1- For State Registrar		2. Date of Death Month Day Year		Reg. No.
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES W. CHANEY</b>		3. Time of Death 6:55 P. M.	
Funeral Director	4a. Facility Name (If not institution, give street and number) <b>BALTIMORE VETERANS AFFAIRS MED</b>		4b. City, Town, or Location of Death <b>CAL CENTER, BALTIMORE CITY</b>	
To Be Completed by Funeral Director	4c. County of Death			
5. Social Security Number <b>215-44-3243</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>59 Yrs.</b>	8. If Under 1 Year Months Days Hours Min. If Under 24 Hrs.
9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10. Date of Birth (Month, Day, Year) <b>June 13, 1947</b>		11. Usual Residence of Decedent 10a. State <b>District of Columbia</b>
10b. County <b>Washington</b>		10c. City, Town or Location <b>Washington, DC</b>		10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
10e. Street and Number <b>2224 F Street, NW</b>		10f. Zip Code <b>20037</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> If Yes, Give Year or Dates: <b>1968-72</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>	14. Race - American Indian, Black, White, etc. <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>		16b. Kind of Business/Industry <b>unknown</b>
17. Father's Name (First, Middle, Last) <b>James Everett Chaney</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Louise Mavors</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Aimee Saylor, Eligibility Clerk</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Decedent Affairs, VA Maryland Health Care, Perry Point, MD 21902</b>		
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>	Date <b>09/15/06</b>	20c. Location - City or Town, State <b>Clinton, Maryland</b>
21. Signature of Funeral Service Licensee <b>Thomas M. Patterson, Jr.</b>		22. Name and Address of Facility <b>Lee A. Patterson &amp; Son Funeral Home, P.A. Perryville, Maryland 21903-0766</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ASPIRATION</b>		Approximate Interval Between Onset and Death <b>four days</b>	
23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>		23d. Date of delivery Month Day Year
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>		23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day Year) <b>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29c. License number <b>AU 4176435 H17421</b>		
29b. Signature and title of certifier <b>JM, M.D.</b>		29d. Date signed (Month, Day, Year) <b>September 3, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NEDA HOMAYOUNPOUR, M.D.</b>		31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		
32. Registrar's Signature <b>James B. Jones</b>				

Baltimore, Maryland 21215-0036

# 23A  
Division of Vital Records, P.O. Box 68760,  
Medical Certification: To Be Completed by Physician/Medical Examiner  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached (or used as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28-a show any injury or other traumatic event, the medical examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30506

Reg. No.

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Virginia Buckler Dixon</b>							2. Date of Death Month Day Year <b>September 8, 2006</b>	3. Time of Death 6:40 A.M.
	4a. Facility Name (If not institution, give street and number) <b>3901 Plum Point Road</b>			4b. City, Town, or Location of Death <b>Huntingtown</b>			4c. County of Death <b>Calvert</b>		
Funeral Director	5. Social Security Number <b>213-38-1852</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 17, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>			10b. County <b>Calvert</b>			10c. City, Town or Location <b>Huntingtown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>3901 Plum Point Road</b>			10f. Zip Code <b>20639</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>12</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify:	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife / Farmer</b>			16b. Kind of Business/Industry <b>Agriculture</b>		
	17. Father's Name (First, Middle, Last) <b>Maurice Miller Buckler</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Hall</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>James N. Dixon, III (Son)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3885 Plum Point Road, Huntingtown, Maryland 20639</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► St. S. Smith</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Southern Mem. Gardens</b>			Date <b>9/13/2006</b>	20c. Location - City or Town, State <b>Dunkirk, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>► St. S. Smith</b>			22. Name and Address of Facility Rausch Funeral Home, P.A. <b>4405 Broome's Island Road, Port Republic, Maryland 20676</b>					
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>CARCINOMA OF THE PANCREAS</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death <b>3 years</b></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{</p>								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATRIAL FIBRILLATION, PERIPHERAL NEUROPATHY</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <b>► John H. Weigert, M.D.</b>			29c. License number <b>DQ6358</b>			29d. Date signed (Month, Day, Year) <b>SEPT. 11, 2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN WEIGERT, M.D. - PRINCIPAL FREDERICK, MD 20678</b>								
	31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>			32. Registrar's Signature <b>► Barbara B. Appler</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

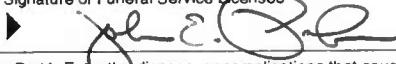
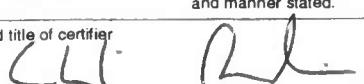
State of Maryland / Department of Health and Mental Hygiene

1- For AMEND#31, DPS, MoCo, 9/12/06  
State  
Registered AMEND#23a, per MD, 9/12/06, DPS, MoCo

Certificate of Death

Reg. No.

2006 30507

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death	
	Xuan Hoang Dang				September 10, 2006 3:15 aM		
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death	
	1411 Bankert Terrace			Abingdon		Harford	
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	220-31-7618		58			March 3, 1948	Vietnam
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Maryland	Harford	Abingdon					
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
1411 Bankert Terrace			21009			Vietnam	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Warehouse			
17. Father's Name (First, Middle, Last) Phuong Dang				18. Mother's Name (First, Middle, Maiden Surname) Trinh Ho Thi			
19a. Informant's Name/Relationship (Type, Print) Mai Xuen Dang/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 Bankert Terrace, Abingdon, MD 21009					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) ParkLawn Memorial Park		Sept. 12, 2006		20c. Location - City or Town, State Rockville, Maryland	
21. Signature of Funeral Service Licensee ► 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Non small cell lung cancer
	a. Due to (or as a consequence of): 						Approximate Interval Between Onset and Death 18 months
	b. Due to (or as a consequence of):						
	c. Due to (or as a consequence of):						
	d. Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how injury occurred	
						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29d. Date signed (Month, Day, Year) 09/11/2006	
29b. Signature and title of certifier ► 						29c. License number D0061040	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Rudin, MD PhD 1550 Orleans St, CRB2 544, ND 21231						31. Date filed (Month, Day, Year) Sep 12 2006	
32. Registrar's Signature ► 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
1- For Amend #23a PI, Line c per MD,g600, 10/31/06, II Certificate of Death 2006 30508  
State Registrar Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>June Edith Dunning</b>				2. Date of Death Month Day Year <b>SEPTEMBER 13, 2006</b>	3. Time of Death <b>7:45 P M</b>		
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>		4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>			
Funeral Director	5. Social Security Number <b>230-50-5600</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 20 1920</b>	9. Birthplace (State or Foreign Country) <b>England</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>1303 The Terrace</b>			10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Personal Residence</b>			
	17. Father's Name (First, Middle, Last) <b>Herbert F. Turpin</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Jessie Yearron</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Corinne J. Swartz (daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1303 The Terrace Hagerstown Maryland 21742</b>				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Daniel O'Falley</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory 9-16-2006</b>		Date <b>2006</b>	20c. Location - City or Town, State <b>Smithsburg Crematory</b>		
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Corinne J. Swartz</b>			22. Name and Address of Facility Douglas A. Fiery Funeral Home <b>1331 Eastern Blvd. N. Hagerstown Maryland 21742</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Ischemic Colitis</b> Due to (or as a consequence of): <b>Atherosclerotic Vascular Disease and</b> Due to (or as a consequence of): <b>Infection with Escherichia coli</b> Due to (or as a consequence of): <b>Seizure disorder epilepsy nuclear.</b> <b>Hypoalbuminemia. Essential hypertension.</b>						Approximate Interval Between Onset and Death <b>0157:H7</b>	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure disorder epilepsy nuclear.</b> <b>Hypoalbuminemia. Essential hypertension.</b>							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>DZ3815</b>		29d. Date signed (Month, Day, Year) <b>9.14.06</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mary E. Money, M.D. 354 Mill St. Hagerstown, MD 21740</b>							
	31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>		32. Registrar's Signature <b>Barbara B. Speer</b>					

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30510

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month 09	Day 08	Year 2006	3. Time of Death 1:00 AM		
Lillian V. Devane						
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
Woodside Nursing Facility	Silver Spring	Montgomery				
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 10-22-1921	9. Birthplace (State or Foreign Country) NC
579-40-1930						

Usual Residence of Decedent  
10a. State  
DC  
10b. County  
10c. City, Town or Location  
Washington  
10e. Street and Number  
2806 Naylor Rd SE #127  
10f. Zip Code  
20020  
10g. Citizen of What Country?  
USA

To Be Completed by Funeral Director

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+) 1	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager	16b. Kind of Business/Industry FAA/Government

17. Father's Name (First, Middle, Last) Henry Newton	18. Mother's Name (First, Middle, Maiden Surname) Vandolia Highsmith
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19a. Informant's Name/Relationship (Type, Print) Linda McAllister/Niece	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Ots St NE, Washington, DC 20018
--	---

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery	Date 09-14-06	20c. Location - City or Town, State Washington, DC
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW, Wash, DC 20011
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Approximate Interval Between Onset and Death
a. Gastro Intestinal Bleeding Due to (or as a consequence of):	
b. Arterio Venous Malformation Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

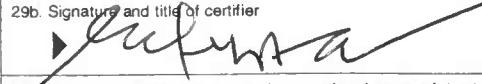
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Of Chronic Disease	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
---	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
---	--	---

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
--	---------------------------------------	---------------------	--	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier 	29c. License number D 32332	29d. Date signed (Month, Day, Year) 09-13-06
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, M.D. 9801 Georgia Ave. Silver Spring, MD 20902 Suite 220
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31. Date filed (Month, Day, Year) SEP 13 2006	32. Registrar's Signature 
--	--

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30511  
Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached or used as the burial-transit

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Donald R Damiano</i>		09 09 2006		9:10 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>142 Paradise Heights</i>		<i>Oakland, Md 21550</i>		<i>Gerrrett</i>
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>81</i> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <i>4-8-25</i>
10a. State <b>FL</b>		10b. County <b>Lee</b>	10c. City, Town or Location <b>Fort Myers Beach</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>18010 San Carlos Blvd.</b>		10f. Zip Code <b>33931</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status  <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:  <b>4 yrs.</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  <b>white</b>
15. Decedent's Education (Specify only highest grade completed)  <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <b>College (1-4 or 5+)</b>		16b. Kind of Business/Industry <b>Pittsburgh Allied Fabricator</b>
17. Father's Name (First, Middle, Last) <b>Nicholas Damiano</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Antoinette Casale</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Merian E. Damiano/wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18010 San Carlos Blvd., Fort Myers Beach, FL 33931</b>		
20a. Method of Disposition  <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Clair Mausoleum</b>		Date <b>Sept 14, 2006</b>
21. Signature of Funeral Service Licensee  		22. Name and Address of Facility <b>Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
a. Due to (or as a consequence of):  <b>The heart attack</b>		b. Due to (or as a consequence of):  <b>Cancer</b>		
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy  <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)  Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>summer home</b>		
27. Manner of Death  <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?  <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D-23979</b>		
29b. Signature and title of certifier  		29d. Date signed (Month, Day, Year) <b>Sept 10, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert A. Goralski, M.D., 311 N. 4th St., Oakland, MD 21550</b>				
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature  		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

1- For  
State  
Registrar

Reg. No. 2006 30512

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

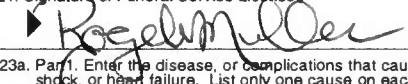
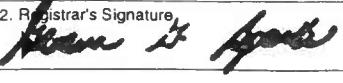
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event,  Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>DONNIE LENN DOSTER</b>		2. Date of Death Month Day Year <b>SEPTEMBER 8 2006</b>		3. Time of Death <b>3:20 P M</b>
4a. Facility Name (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>FREDERICK</b>		4c. County of Death <b>FREDERICK</b>
5. Social Security Number <b>258-17-6428</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>Nov. 5, 1959</b>
Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>
10e. Street and Number <b>6723 Ford Road</b>		10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 10		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Drywall Mechanic</b>		16b. Kind of Business/Industry <b>Construction</b>
17. Father's Name (First, Middle, Last) <b>Charles Glenn Doster</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Betty Lou Alexander</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Terrie Doster/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6723 Ford Road, Frederick, MD 21702</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Mem. Gards</b>		Date <b>9/12/2006</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Stauffer Funeral Home, PA</b> <b>1621 Opossumtown Pike, Frederick, MD 21702</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Approximate Interval Between Onset and Death <b>days</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>multisystem organ failure</b> Due to (or as a consequence of):		
		b. <b>Sepsis</b> Due to (or as a consequence of):		<b>days</b>
		c. <b>Cirrhosis of the Liver</b> Due to (or as a consequence of):		<b>years</b>
d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>alcohol abuse</b>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>MD056890</b>		29d. Date signed (Month, Day, Year) <b>9/9/2006</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Caroline Besser</b>				
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30513

For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carolyn Cecelia Duffy</b>							2. Date of Death Month Day Year <b>September 6 2006</b>	3. Time of Death A.M. <b>3:30</b>
	4a. Facility Name (If not institution, give street and number) <b>Snow Hill Nursing &amp; Rehabilitation Ctr.</b>			4b. City, Town, or Location of Death <b>Snow Hill</b>			4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number <b>218-24-5759</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 13, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Worcester</b>	10c. City, Town or Location <b>Snow Hill</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>102 Mason Street</b>			10f. Zip Code <b>21863</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) laborer			16b. Kind of Business/Industry <b>Canning Factory</b>		
	17. Father's Name (First, Middle, Last) <b>Wallace Wharton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Georgiana Gillett</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Purnell/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>102 Mason Street - Snow Hill, Maryland 21863</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. James Church Cem.</b>		Date	20c. Location - City or Town, State <b>09/09/2006 Snow Hill, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Loretta B. Jolley</b>				22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD <b>JOLLEY MEMORIAL CHAPEL</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause per each line. Immediate Cause (Final disease or condition resulting in death) <b>Dementia</b> Approximate Interval Between Onset and Death <b>8 yrs.</b>								
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>28d. Describe how injury occurred</b>								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <b>Sarah R. Barat, MD</b>								
	29c. License number <b>J 54422</b>								
	29d. Date signed (Month, Day, Year) <b>9-6-2006</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1654- Market St., Pocomoke, MD 21851</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>		32. Registrar's Signature <b>Sarah R. Barat</b>						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: Item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No.

2006 30514

1. For State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Warner Densford</b>				2. Date of Death Month Day Year <b>August 31, 2006</b>	3. Time of Death 2046 hrs	
Funeral Director	4a. Facility Name (if not institution, give street and number) <b>Peninsula Regional Medical Center</b>			4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
To Be Completed by Funeral Director	5. Social Security Number <b>578-48-6719</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b>	If Under 1 Year Months Days Hours Min. Yrs.	8. Date of Birth (MM/DD/YYYY) <b>10-24-1935</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
Baltimore, MD 21215-0036	10a. State <b>MD</b>			10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Willards</b>	
						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Physician /Medical Examiner	10e. Street and Number <b>9132 Bethel Road</b>			10f. Zip Code <b>21874</b>		10g. Citizen of What Country? <b>USA</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1953-1956</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Operator</b>		16b. Kind of Business/Industry <b>Sporting Goods</b>	
	17. Father's Name (First, Middle, Last) <b>Robert L. Densford</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Viviane Miller</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Deborah Densford Sloan-daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7204 Longwood Dr., Bethesda, MD 20817</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Melissa Henry Blake</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crematory of Delmarva</b>		Date <b>9-11-2006</b>	
						20c. Location - City or Town, State <b>Delmar, DE</b>	
	21. Signature of Funeral Service Licensee <i>Melissa Henry Blake</i>			22. Name and Address of Facility <b>Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804</b>			
	23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple Injuries</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):						
	Approximate Interval Between Onset and Death						
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:				
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Aug 31, 2006</b>	28b. Time of Injury <b>1800 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Passenger auto auto collision</b>	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Local Street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Gumboro Road and East Line Road, Pittsville, MD</b>		
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>Margarita Korell</i>			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 2, 2006</b>	
	30. Name and address of person who completed cause of death (Item 23a) <b>Margarita Korell MD. Assistant Medical Examiner</b>			31. Date filed (Month, Day, Year) <b>SEP 11 2006</b> 32. Registrar's Signature <i>Bevane D. Jones</i>			

*S. Sales  
1/24*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30515

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jennie Lee Elliton</b>							2. Date of Death Month: <b>SEPTEMBER</b> Day: <b>9</b> Year: <b>2006</b>	3. Time of Death <b>2:50AM</b>
	4a. Facility Name (If not institution, give street and number) <b>St. Mary's Hospital</b>				4b. City, Town, or Location of Death <b>Leonardtown</b>			4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>577-26-4918</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug 21, 1924</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Calvert</b> 10c. City, Town or Location <b>Huntington</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>155 Sun Park Lane</b>			10f. Zip Code <b>20639</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>If Yes, Give Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: White</b>			14. Race - American Indian, Black, White, etc.	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Glen Heathwal Coakley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Hannah Coakley</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>James Elliton (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1451 Ponds Wood Road Huntington, MD 20639</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Gary J. Goff</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cem.</b>			Date <b>Sep 16</b>	20c. Location - City or Town, State <b>Clinton, MD</b>	
	21. Signature of Funeral Service Licensee <b>Gary J. Goff</b>				22. Name and Address of Facility Lee Funeral Home Calvert, PA <b>8125 Southern Maryland Blvd. Owings, MD 20736</b>				
Physician /Medical Examiner	<p>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death) <b>Septic Shock &amp; Multisystem Failure</b></p> <p>Approximate Interval Between Onset and Death <b>2 days</b></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): <b>Pneumonia &amp; Urinary tract infection - Days</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><b>Severe Protein Malnutrition</b></p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p>								
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
	<p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p>								
	<p>26. Place of Death (Check only one) <b>Inpatient</b></p>								
	<p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p>								
	<p>28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
	<p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p>								
	<p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>								
	<p>29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p>								
	<p>29b. Signature and title of certifier <b>David C. Allen MD</b></p>								
	<p>29c. License number <b>D25230</b></p>								
	<p>29d. Date signed (Month, Day, Year) <b>9-10-06</b></p>								
	<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR DAVID ALLEN PO BOX 527 LEONARDTOWN MD 20650</b></p>								
	<p>31. Date filed (Month, Day, Year) <b>SEP 13 2006</b></p>								
	<p>32. Registrar Signature <b>Leanne L. Parker</b></p>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
1- For Amend item#21, per FH, G859, 9/26/06 tT Certificate of Death Reg. No. 2006 30516  
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert G. Eagle, Sr.</b>							2. Date of Death Month <b>09</b> Day <b>18</b> Year <b>06</b>	3. Time of Death <b>2217 M</b>
	4a. Facility Name (If not institution, give street and number) <b>LWMHS - Braddock Campus</b>			4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>ALLEGANY</b>			
Funeral Director	5. Social Security Number <b>233-34-6151</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>7/27/25</b>	9. Birthplace (State or Foreign Country) <b>Keyser, WV</b>
	Usual Residence of Decedent 10a. State <b>WV</b> 10b. County <b>Mineral</b> 10c. City, Town or Location <b>Keyser</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>1055 Georgia Avenue</b>				10f. Zip Code <b>26726</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Brakeman</b>			16b. Kind of Business/Industry <b>Railroad</b>				
	17. Father's Name (First, Middle, Last) <b>Harry F. Eagle</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Hodges</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Virgie Eagle/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1055 Georgia Ave., Keyser, WV 26726</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Potomac Memorial</b>			Date <b>9/23/06</b>	20c. Location - City or Town, State <b>Keyser, WV</b>		
	21. Signature of Funeral Service Licensee <b>► Harold Dean Nofsinger (per DVR)</b>		22. Name and Address of Facility <b>Markwood Funeral Home, Inc. P.O. Box 912, Keyser, WV 26726</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>T-cell lymphoma, metastatic</b>								Approximate Interval Between Onset and Death <b>1y</b>
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>								28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>City or Town, State</b>
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) <b>Sept. 20, 2006</b>
	29b. Signature and title of certifier <b>► A. J. Bellino MD</b>				29c. License number <b>D 0017565</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A. J. Bellino MD 922 N &amp; 1 Hwy 62 Suite 200 21802</b>								
	31. Date filed (Month, Day, Year) <b>SEP 26 2006</b>		32. Registrar's Signature <b>Karen B. Spotts</b>						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30517  
Reg. No.

1- For  
State  
Registrar

**Physician  
/Medical  
Examiner**

**Funeral  
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23c or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 7:55 P M
MAMIE K. FEELING		SEPT. 10, 2006		
4a. Facility Name (If not institution, give street and number)  6518 ADAK STREET - RESIDENCE		4b. City, Town, or Location of Death  SEAT PLEASANT		4c. County of Death  PRINCE GEORGE
5. Social Security Number  422-07-8241		6. Sex  1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)  102 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10-11-03
9. Birthplace (State or Foreign Country)  ALABAMA				
Usual Residence of Decedent				
10a. State  MARYLAND	10b. County  PRINCE GEORGE	10c. City, Town or Location  SEAT PLEASANT		
10e. Street and Number  6518 ADAK STREET		10f. Zip Code  20743		10g. Citizen of What Country?  U. S. A.
11. Marital Status  1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc.  Specify: BLACK
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  College (1-4 or 5+) INSURANCE AGENT		16b. Kind of Business/Industry  NORTH CAROLINA MUTUAL LIFE INS. CO.
17. Father's Name (First, Middle, Last)  DOC HENRY KNIGHT		18. Mother's Name (First, Middle, Maiden Surname)  JOSEPHINE JORDAN		
19a. Informant's Name/Relationship (Type, Print)  MARY E. BRISKER - NIECE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  6518 ADAK STREET SEAT PLEASANT, MD 20743		
20a. Method of Disposition  1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)  FT. LINCOLN CEMETERY	Date 9/16/06	20c. Location - City or Town, State  BRENTWOOD, MD
21. Signature of Funeral Service Licensee  Theodore C. Pinckney		22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., DC20002		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Malaria				
Approximate Interval Between Onset and Death 1 month				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Severe dementia				
2 months				
a. Due to (or as a consequence of):  Malaria				
b. Due to (or as a consequence of):  Severe dementia				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
				28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D27521		
29b. Signature and title of certifier  K. Leach		29d. Date signed (Month, Day, Year) Sep. 13, 06		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KADIE LEACH, M. D. 9500 ANNAPOLIS ROAD SUITE #A1 LANHAM, MD 20706				
31. Date filed (Month, Day, Year)  SEP 13 2006		32. Registrar's Signature K. Leach		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30518

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
<b>Cora H. Ferreola</b>	<b>September 4, 2006</b>	<b>9:45 P M</b>

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
<b>South River Health &amp; Rehab. Center</b>	<b>Edgewater</b>	<b>Anne Arundel</b>

Funeral  
Director

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/20/1927	9. Birthplace (State or Foreign Country) Maryland
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Usual Residence of Decedent			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State <b>West Virginia</b>	10b. County <b>Randolph</b>	10c. City, Town or Location <b>Elkins</b>			

10e. Street and Number <b>1408 Lavalette Ave.</b>	10f. Zip Code <b>26241</b>	10g. Citizen of What Country? <b>USA</b>
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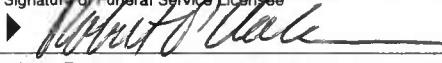
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
--	---	---	---

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Hairstylist</b>	16b. Kind of Business/Industry <b>Salon</b>
---	--	--

17. Father's Name (First, Middle, Last) <b>Clarence K. Hardy</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie Disney</b>
---	---

19a. Informant's Name/Relationship (Type, Print) <b>Carol S. Breitzman/ Friend</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1408 Lavalette Ave., Elkins WV 26241</b>
---	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Epiphany Episcopal Ch.</b>	Date <b>9-8-06</b>	20c. Location - City or Town, State <b>Forestville, MD</b>
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility <b>George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037</b>
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
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23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): <b>DIABETES</b>
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	b. Due to (or as a consequence of):
--	-------------------------------------

	c. Due to (or as a consequence of):
--	-------------------------------------

	d. Due to (or as a consequence of):
--	-------------------------------------

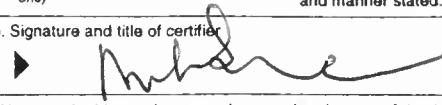
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
--	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
---	--

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
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29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician- To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
---	--	--

29b. Signature and title of certifier 	29c. License number <b>D57313</b>	29d. Date signed (Month, Day, Year) <b>9/7/06</b>
--	--------------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>827 LINDEN AVE BALTIMORE MD 21043, MITUL DAVE</b>
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31. Date filed (Month, Day, Year) <b>SEP 08 2006</b>	32. Registrar's Signature 
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Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 26a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30519

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<b>Agostino Ferrantelli</b>		September 18, 2006 04:10 AM		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
54 Gina Lane		Elkton		Cecil
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 10, 1947
075-52-4838				9. Birthplace (State or Foreign Country) Italy
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X		
10a. State Md.	10b. County Cecil	10c. City, Town or Location Elkton		
10e. Street and Number 54 Gina Lane		10f. Zip Code 21921		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4	College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner	16b. Kind of Business/Industry Restaurants	
17. Father's Name (First, Middle, Last) Camillo Ferrantelli		18. Mother's Name (First, Middle, Maiden Surname) Liboria Navarra		
19a. Informant's Name/Relationship (Type, Print) Madelyn Ferrantelli, Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Gina Lane, Elkton, Md. 21921		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All Saints Cemetery	Date	20c. Location - City or Town, State 9/21/06 Wilmington, De.
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Andrew G. Gee Funeral Home	259 E. Main St., Elkton, Md. 21921	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 14 months		
{ a. _____ Due to (or as a consequence of): Gastric cancer				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier 			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Farkas, MD Seasons Hospice, Elkton, MD		29c. License number D15314		29d. Date signed (Month, Day, Year) September 18, 2006
31. Date filed (Month, Day, Year) SEP 19 2006	32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30520

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edna Mae Frantz</b>							2. Date of Death Month Day Year <b>September 6 2006</b>	3. Time of Death 1:05 A M
	4a. Facility Name (If not institution, give street and number) <b>409 Spruce St.</b>			4b. City, Town, or Location of Death <b>Westernport</b>			4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>218-64-7793</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Aug. 17, 1926</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent 10a. State <b>MD.</b> 10b. County <b>Allegany</b> 10c. City, Town or Location <b>Westernport</b>							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>409 Spruce St.</b>			10f. Zip Code <b>21562</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Housework</b>		
	17. Father's Name (First, Middle, Last) <b>Alvie Everly</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alta Helms</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Charles Moorehead/ son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>409 Spruce St, Westernport, Maryland 21562</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Philos Cemetery</b>			Date <b>09/08/2006</b>	20c. Location - City or Town, State <b>Westernport Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Boal Funeral Home 111 Church St., Westernport, Maryland 21562</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Pancreatic Cancer</b> Due to (or as a consequence of): _____ b. _____ c. _____ d. _____ Approximate Interval Between Onset and Death <b>unknown</b>								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D0060478</b>				
	29b. Signature and title of certifier 				29d. Date signed (Month, Day, Year) <b>9/16/06</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Ahmad</b> 625 Kent Ave., Cumberland, Maryland, 21502								
	31. Date filed (Month, Day, Year) <b>SEP - 7 2006</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30521

Reg. No.

1- For State Register		1. Decedent's Name (First, Middle, Last) <b>Robert John Fisher</b>			2. Date of Death Month Day Year <b>September 09 2006</b>			3. Time of Death <b>1131 AM</b>					
Physician /Medical Examiner	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>			4b. City, Town, or Location of Death <b>Hagerstown</b>			4c. County of Death <b>Washington</b>						
	5. Social Security Number <b>212-74-4453</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Nov. 13, 1957</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b>			10b. County <b>Frederick</b>			10c. City, Town or Location <b>Thurmont</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>16005 St. Anthony Road</b>			10f. Zip Code <b>21788</b>			10g. Citizen of What Country? <b>USA</b>						
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>12</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Drywall Mechanic</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>						
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>			16b. Kind of Business/Industry <b>Construction</b>						
	17. Father's Name (First, Middle, Last) <b>Russell E. Fisher</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Salvaterra</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>Annabelle Toms /Sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16005 St. Anthony Raod, Thurmont, MD 21788</b>									
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Frederick Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Frederick Crematory</b>			Date <b>9/12/2006</b>	20c. Location - City or Town, State <b>Frederick, MD</b>					
	21. Signature of Funeral Service Licensee <b>Kyle Miller</b>			22. Name and Address of Facility <b>Stauffer Funeral Home, PA</b>			104 E. Main Street, Thurmont, MD 21788						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Guns hot Wound</b>			23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <b>Sept. 09, 2006</b>	28b. Time of Injury <b>1000 A M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Self Inflicted Gunshot</b>
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>16005 Saint Anthony Road</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Thurmont, MD</b>									
	29a. Certifier (Check only one) <b>Stephen J. Kotul</b>			29b. Signature and title of certifier <b>Stephen J. Kotul</b>			29c. License number <b>D0056965</b>			29d. Date signed (Month, Day, Year) <b>September 11, 2006</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen J. Kotul 251 C. Anthony Street Hagerstown, MD 21740</b>			31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>			32. Registrar's Signature <b>Stephanie Kotul</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f have any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30522

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death
Cecelia Robb Fichter	September 7, 2006				2:30 p.m.
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				4c. County of Death
Collingswood Nursing & Rehab Center	Rockville				Montgomery

Funeral  
Director

To Be Completed by Funeral Director

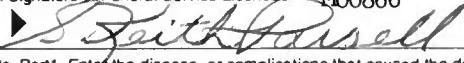
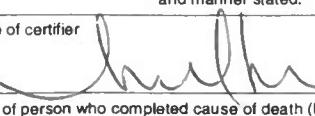
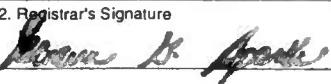
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 20, 1918	9. Birthplace (State or Foreign Country) Pennsylvania												
Usual Residence of Decedent 10a. State Maryland		10b. County Montgomery	10c. City, Town or Location Montgomery Village														
10e. Street and Number 19130 Roman Way			10f. Zip Code 20886	10g. Citizen of What Country? USA													
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3	16b. Kind of Business/Industry Elementary School Teacher		Education												
17. Father's Name (First, Middle, Last) John A. Robb			18. Mother's Name (First, Middle, Maiden Surname) Susan A. Corrigan														
19a. Informant's Name/Relationship (Type, Print) John E. Fichter/ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19130 Roman Way, Montgomery Village, MD 20886														
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Epworth Methodist Cemetery	Date 09/12/2006	20c. Location - City or Town, State Rehoboth Beach, Delaware													
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Parsell Funeral Homes & Crematorium, Atkins-Lodge Chapel 16961 Kings Highway, Lewes, Delaware 19958															
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)																	
<table border="1"> <tr> <td>a.</td> <td>CONGESTIVE HEART FAILURE Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>FAILURE TO THRIVE Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>						a.	CONGESTIVE HEART FAILURE Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	FAILURE TO THRIVE Due to (or as a consequence of):		c.	Due to (or as a consequence of):		d.		
a.	CONGESTIVE HEART FAILURE Due to (or as a consequence of):	Approximate Interval Between Onset and Death															
b.	FAILURE TO THRIVE Due to (or as a consequence of):																
c.	Due to (or as a consequence of):																
d.																	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred												
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number H0051280															
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 9-8-06															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed Elsayyad, M.D. 9715 Medical Center Dr. Suite 201, Rockville, MD 20850																	
31. Date filed (Month, Day, Year) SEP 12 2006		32. Registrar's Signature 															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30523

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY GROSS</b>				2. Date of Death Month 09 Day 03 Year 2006	3. Time of Death 1734h	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>216-48-9619</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Dec 12, 1926</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Churchton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>5506 Dartmouth Street</b>			10f. Zip Code <b>20733</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Domestic</b>		16b. Kind of Business/Industry <b>Someone Else's Home</b>			
17. Father's Name (First, Middle, Last) <b>Ernest Gross</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alverta Starks</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Maria Gross/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Daughter 5506 Dartmouth Street Churchton, MD 20733</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moses Cemetery</b>		Date <b>09/11/06</b>	20c. Location - City or Town, State <b>Lothian, MD</b>		
21. Signature of Funeral Service Licensee <b>Gladys A. Sewell</b>				22. Name and Address of Facility <b>Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Repeated Embolie CJA</b>							Approximate Interval Between Onset and Death <b>10 D</b>
b. Due to (or as a consequence of): <b>Valvular heart disease</b>							year
c. Due to (or as a consequence of): <b>H pertension</b>							year
d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PMT Breast Cancer</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M	28d. Describe how injury occurred		
				<input type="checkbox"/> Yes <input type="checkbox"/> No			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year) <b>Sept 04, 2006</b>
29b. Signature and title of certifier <b>Michael J. Bentum</b>		29c. License number <b>D 21438</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL J. BENTUM 1445 DEFENSE HIGHWAY ANNAPOLIS MD 21401</b>							
31. Date filed (Month, Day, Year) <b>SEP 6 2006</b>		32. Registrar's Signature <b>Leanne B. Spitzer</b>					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event,  Medical Examiner  Funeral Director  Hospital

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30524  
Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kathryn Greene</b>			2. Date of Death Month Day Year <b>September 5, 2006</b>	3. Time of Death 8:55 PM		
	4a. Facility Name (If not institution, give street and number) <b>203 McKendree Ave</b>			4b. City, Town, or Location of Death <b>Annapolis</b>	4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>576-30-2718</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>Oct. 21, 1931</b>	9. Birthplace (State or Foreign Country) <b>Hawaii</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Annapolis</b>					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>203 McKendree Ave</b>			10f. Zip Code <b>21401</b>	10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>2</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>	14. Race - American Indian, Black, White, etc. Specify:			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>	16b. Kind of Business/Industry <b>Legal</b>		
	17. Father's Name (First, Middle, Last) <b>James S. Green</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown Stevens</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Lowell C. Greene / Husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 McKendree Ave. Annapolis, Maryland 21401</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Baltimore Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Crematory</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility John M. Taylor Funeral Home, Inc. <b>147 Duke of Gloucester St. Annapolis, MD 21401</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Colon cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Colon cancer</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____					Approximate Interval Between Onset and Death <b>3 years smoothly</b>	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>D0060046</b>			29d. Date signed (Month, Day, Year) <b>September 6, 2006</b>
	30. Name and address of person who completed certificate of death (Item 23a) (Type, Print) <b>Josh Lawrence, M.D., Ph.D. CRG 186, 1650 Orleans Street, Baltimore, MD 21231</b>						
	31. Date filed (Month, Day, Year) <b>SEP 08 2006</b>			32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death, Alter this certificate has been signed by the attending physician and To the Funeral Director: Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

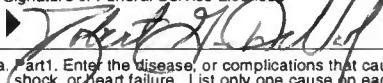
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30525

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Albert A. Gibson</b>							2. Date of Death Month Day Year <b>September 9, 2006</b>	3. Time of Death <b>3:56pm M</b>
	4a. Facility Name (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>148-07-3328</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>89 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Feb. 23, 1917</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent		10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Gaithersburg</b>
To Be Completed by Funeral Director	10e. Street and Number <b>211 Russell Avenue #32</b>			10f. Zip Code <b>20877</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>		
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 5+ Principal</b>			16b. Kind of Business/Industry <b>Montgomery Cty Schools</b>		
	17. Father's Name (First, Middle, Last) <b>Franklin Gibson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Eleanor Corless</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ruth M. Gibson (Wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>211 Russell Avenue #32, Gaithersburg, Md 20877</b>					
	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>			Date <b>9/11/2006</b>	20c. Location - City or Town, State <b>Alexandria, Virginia</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of):  <i>Acute myocardial infarction</i>			Approximate Interval Between Onset and Death <b>2 days</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Due to (or as a consequence of):						
23d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year			
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>			23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>			
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day Year) <b>8/10/2006</b>			28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>20850</b>			
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>1 <input checked="" type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>D38262</b>			29d. Date signed (Month, Day, Year) <b>Sept 10, 2006</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. A. Mendhiratta 2401 Research Blvd Suite 330 Rockville MD</b>			32. Registrar's Signature <b>Bonnie K. Spotts</b>						
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature <b>Bonnie K. Spotts</b>						

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

10 + 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend item 1- For State Registrar #26 per dr/8-11-06/wichd/dls Certificate of Death

Reg. No. 2006 30526

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last)		ESTHER LOUISE GILLIS				2. Date of Death Month Day Year	9 - 4 - 06	3. Time of Death	3:30 AM
Funeral Director		4a. Facility Name (If not institution, give street and number)		CHRISTIAN SHELTER				4b. City, Town, or Location of Death	SALISBURY		
		5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 6 - 7 - 60	9. Birthplace (State or Foreign Country) FLA		
		Usual Residence of Decedent		MD WICOMICO				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		10a. State		10b. County		10c. City, Town or Location FRUITLAND				10g. Citizen of What Country? USA	
		10e. Street and Number 217-POPLAR ST. APT. A-3		10f. Zip Code 21826				10g. Citizen of What Country? USA			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) DISABLED		16b. Kind of Business/Industry NONE					
		17. Father's Name (First, Middle, Last) CLYDE TITUS HESS		18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN							
		19a. Infants Name/Relationship (Type, Print) CHRISTINA WHITE - DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217-POPLAR ST. APT. A-3 FRUITLAND MD 21826							
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Phyllis Rund		20b. Place of Disposition (Name of cemetery, crematory or other place) DELMARVA CREMATORY		20c. Location - City or Town, State 9-11-06 DELMAR DE					
		21. Signature Funeral Service Licensee Phyllis Rund		22. Name and Address of Facility BENIE SMITH F/H 917-W. ISABELLA ST. SALISBURY MD 21801							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Acquired immune deficiency Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
				b. Due to (or as a consequence of):							
				c. Due to (or as a consequence of):							
				d. Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Christian Shelter							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier J. A. Cocker, ms		29c. License number 2002r674				29d. Date signed (Month, Day, Year) 9/11/06			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. Cocker, ms 1746 S. Division St., Salisbury, MD 21804									
		31. Date filed (Month, Day, Year) SEP 11 2006		32. Registrar's Signature Karen B. Jones							

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No.

2006 30527

1- For State  
Registrar**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

Permit Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2 Date of Death Month Day Year		3. Time of Death 0245 hrs	
<b>ENOCH BERNARD GOLPIN III</b>		September 17, 2006			
4a. Facility Name (if not institution, give street and number) <b>Peninsula Regional Medical Center</b>		4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
5. Social Security Number <b>221-48-6610</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>41</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>12/16/1964</b>	
Usual Residence of Decedent 10a. State <b>Md.</b>		10b. County <b>Worcester</b>	10c. City, Town or Location <b>Bishopville</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>9735 Hotel Road</b>		10f. Zip Code <b>21813</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married    2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed    4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No    Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)    College (1-4 or 5+) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer / Grass Cutter</b>		16b. Kind of Business/Industry <b>Ocean City Grass Busters</b>	
17. Father's Name (First, Middle, Last) <b>ENOCH Bernard Golpin Jr.</b>		18 Mother's Name (First, Middle, Maiden Surname) <b>Deborah Handy</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Deborah Golpin (mother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9735 Hotel Rd. Bishopville, md 21813</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial    2 <input type="checkbox"/> Cremation    3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation    5 <input type="checkbox"/> Other Specify <b>[Signature]</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ZonR Golden Acres</b>		Date <b>9-23-06</b>	20c. Location - City or Town, State <b>Bishopville, Md</b>
21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Bennie Smith Funeral Home 917 W. Isabella St SALISBURY MD 21801</b>			

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure! List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple injuries</b> Due to (or as a consequence of):		
b. _____ Due to (or as a consequence of):		
c. _____ Due to (or as a consequence of):		
d. _____ Due to (or as a consequence of):		
<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED    #1,23a,27,28a-f, perME, g862, 12/7/06 TT		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth    2 <input type="checkbox"/> Fetal death    3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death    5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> Unknown					

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No    3 <input type="checkbox"/> Probably    4 <input type="checkbox"/> Unknown
_____		
_____		

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes    2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient    2 <input type="checkbox"/> ER/Outpatient    3 <input type="checkbox"/> DOA    Other: 4 <input type="checkbox"/> Nursing Home    5 <input type="checkbox"/> Residence    6 <input type="checkbox"/> Other.		23d. Date of delivery Month Day Year	
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27. Manner of Death 1 <input type="checkbox"/> Natural    5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident    6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide    7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Fnd 9/16/2006</b>		28b. Time of Injury <b>Fnd 9:55 pm</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>roadway</b>		28d. Describe how injury occurred <b>unknown</b>	
				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Polybranch Road @ Selbyville, Delaware</b>	

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 17, 2006</b>
--	--	--	--	--

30. Name and address of person who completed cause of death (Item 23a) <b>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>		32. Registrar's Signature <b>[Signature]</b>		
--	--	---	--	--

31. Date filed (Month, Day, Year) <b>SEP 19 2006</b>	33. Date filed (Month, Day, Year) <b>SEP 19 2006</b>
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**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner****State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30528

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Thelma L. Herbert</b>							2. Date of Death Month Day Year <b>September 19, 2006</b>	3. Time of Death 6:00 AM		
	4a. Facility Name (If not institution, give street and number) <b>1919 Pulaski Highway</b>			4b. City, Town, or Location of Death <b>Havre de Grace</b>			4c. County of Death <b>Harford</b>				
Funeral Director	5. Social Security Number <b>215-58-0978</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>55 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>April 5, 1951</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
	Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Havre de Grace</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>1919 Pulaski Highway</b>			10f. Zip Code <b>21078</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: White</b>			14. Race - American Indian, Black, White, etc.			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>			16b. Kind of Business/Industry <b>Public School</b>				
	17. Father's Name (First, Middle, Last) <b>R.L. Weddle</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Lassie Bond</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Teresa Lyn Herbert (Daughter)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1919 Pulaski Highway, Havre de Grace, MD 21078</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Burial</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Mem. Gdns.</b>		Date <b>9/22/06</b>	20c. Location - City or Town, State <b>Bel Air, Maryland</b>				
	21. Signature of Funeral Service Licensee <b>Dana C. Zellman</b>					22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>weeks</b>		
	<p>a. <b>Pancreatic and hepatic cancer</b> Due to (or as a consequence of): <b>Tumors</b></p> <p>b. <b>Heartitis C</b> Due to (or as a consequence of): <b>Inflammation of liver</b></p> <p>c. <b>Heartitis C</b> Due to (or as a consequence of): <b>Inflammation of liver</b></p> <p>d. <b>Heartitis C</b> Due to (or as a consequence of): <b>Inflammation of liver</b></p>								<b>years</b>		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <b>M</b> 28b. Time of Injury <b>M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore MD 21221</b>		
	29b. Signature and title of certifier <b>Dana C. Zellman MD</b>								29c. License number <b>DOV32392</b>		29d. Date signed (Month, Day, Year) <b>9/20/06</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1245 Eastern Boulevard</b>								31. Date filed (Month, Day, Year) <b>SEP 26 2006</b>		
									32. Registrar's Signature <b>[Signature]</b>		

Baltimore City Health Department  
Division of Vital Records, P.O. Box 68760, OKCIS

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg No.

2006 30529

1- For State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dick Phillip Hoke</b>						2. Date of Death Month Day Year <b>September 9, 2006</b>	3. Time of Death 2111 hrs	
	4a. Facility Name (if not institution, give street and number) <b>Prince George County Hospital</b>			4b. City, Town, or Location of Death <b>Cheverly</b>			4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>445-30-5090</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>Sep 15, 1929</b>	9. Birthplace (State or Foreign Country) <b>OK</b>		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Calvert</b>			10c. City, Town or Location <b>Lusby</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>424 Hawthorn Court</b>			10f. Zip Code <b>20657</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify		14. Race - American Indian, Black, White, etc. Specify <b>White</b>
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28- f show any injury or other traumatic event, the Medical Examiner must be notified at once.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Director of Housing</b>			16b. Kind of Business/Industry <b>Gallaudet Univ.</b>		
	17. Father's Name (First, Middle, Last) <b>Jess</b>			18 Mother's Name (First, Middle, Maiden Surname) <b>Hoke</b> <b>Melba</b> <b>Remund</b>					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Janet Hoke (wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>424 Hawthorn Court Lusby, MD 20657</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify <b>Gary J. Goff</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>			Date <b>Sept 11 2006</b>	20c. Location - City or Town, State <b>Clinton, MD</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Gary J. Goff</b>			22. Name and Address of Facility <b>Lee Funeral Home Calvert, PA</b>			8125 Southern Maryland Blvd. Owings, MD 20736		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			a. <b>Multiple Injuries with complications</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			Approximate Interval Between Onset and Death		
23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26 Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) <b>Jul 27, 2006</b>	28b. Time of Injury <b>1428 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Driver auto auto collision</b>			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Major Road / Highway</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Route 235 South Jones Wharf Road, Hollywood,</b>			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated			29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>September 10, 2006</b>			
30. Name and address of person who complete cause of death (Item 23a) <b>Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>			32. Registrar's Signature <b>James D. Spates</b>						
31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

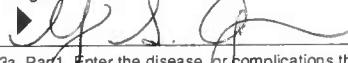
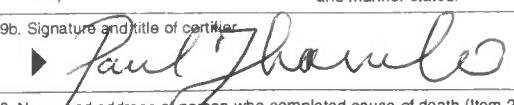
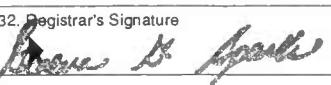
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30530

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sharon Marie Hunter</b>						2. Date of Death Month Day Year <b>September 10, 2006</b>	3. Time of Death 5:00 a.m.		
	4a. Facility Name (If not institution, give street and number) <b>1 Gruenthaler Court</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>190-36-1004</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61 Yrs.</b>		If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Sept. 26, 1944</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>1 Gruenthaler Court</b>			10f. Zip Code <b>20851</b>			10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Elementary/Secondary (0-12)</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>College (1-4 or 5+)</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Transcriber</b>			16b. Kind of Business/Industry <b>Medical</b>			
17. Father's Name (First, Middle, Last) <b>William Henry Everhart</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Josephine Elersic</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Donald Hunter / Spouse</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Gruenthaler Court; Rockville, Maryland 20851</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory</b>		Date <b>9/12/2006</b>	20c. Location - City or Town, State <b>Brentwood, Maryland</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852</b>					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Ureteral Cancer</b>					Approximate Interval Between Onset and Death <b>9 months</b>					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>a. Ureteral Cancer</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D0061083</b>		29d. Date signed (Month, Day, Year) <b>SEPT 11, 2006</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Thambi, M.D.</b> <b>9707 Medical Center Drive; Rockville, MD 20850</b>										
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event,  Medical Examiner  Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

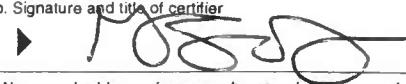
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30531

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death		
	Ethel Compton Hill							September 7, 2006	11:45am M		
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death			
	19443 Brassie Place #103				Montgomery Village			Montgomery			
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 27, 1919	9. Birthplace (State or Foreign Country) Massachusetts			
	579-10-6019										
Usual Residence of Decedent											
10a. State		10b. County		10c. City, Town or Location					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Maryland		Montgomery		Montgomery Village							
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?			
19443 Brassie Place #103				20886				United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2			Contracting Officer			16b. Kind of Business/Industry Federal Government		
17. Father's Name (First, Middle, Last) Thomas Compton					18. Mother's Name (First, Middle, Maiden Surname) Lottie Lee Womack						
19a. Informant's Name/Relationship (Type, Print) Barbara Louise Staley (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Jefferson Street, Colonial Beach, VA 22443						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) National Memorial Park			Date		20c. Location - City or Town, State Falls Church, Virginia			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Breast Cancer Due to (or as a consequence of):											
b. _____ Due to (or as a consequence of):											
c. _____ Due to (or as a consequence of):											
d. _____											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 43083									
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) September 7, 2006									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George A. Sotos M.D. 9707 Medical Center Drive #300, Rockville, MD 20850											
31. Date filed (Month, Day, Year) SEP 12 2006		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 23e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30532

1- For  
State  
Registrar

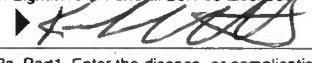
Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Francis Bond Herlihy</b>				2. Date of Death Month Day Year <b>September 6, 2006</b>		3. Time of Death <b>10:20 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Long Green Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>032-09-1903</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11/20/1921</b>	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>
	Usual Residence of Decedent 10a. State <b>Florida</b> 10b. County <b>Palm Beach</b> 10c. City, Town or Location <b>West Palm Beach</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1515 South Flagler Drive #604</b>				10f. Zip Code <b>33401</b>	10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>		5+	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Industrial Executive</b>			16b. Kind of Business/Industry <b>Aerospace</b>
	17. Father's Name (First, Middle, Last) <b>Frank Herlihy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anne Cronin</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mark F. Herlihy / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5709 Greenleaf Road Baltimore, MD 20210</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Francis Xavier Cemetery</b>		Date <b>09/11/2006</b>	20c. Location - City or Town, State <b>Barnstable, MA</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715</b>		
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Chronic Obstructive Pulmonary Disease</b> Approximate Interval Between Onset and Death <b>Unknown</b>						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Aspiration Pneumonia</b> Approximate Interval Between Onset and Death <b>Unknown</b>						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Lung Cancer</b> Approximate Interval Between Onset and Death <b>Unknown</b>						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hypertension</b> <b>Hypernatremia</b> <b>Renal Insuff</b>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hyponatremia</b> <b>Renal Insuff</b>						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						
	28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier  <b>MO</b>						
	29c. License number <b>D0059056</b>						
	29d. Date signed (Month, Day, Year) <b>9/7/06</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Daniel Salazar</b>						
	31. Date filed (Month, Day, Year) <b>SEP 08 2006</b> 32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30533  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Violet Marie Hersh</b>							2. Date of Death Month Day Year <b>September 11, 2006</b>	3. Time of Death A M <b>6:30</b>	
	4a. Facility Name (If not institution, give street and number) <b>Goodwill Mennonite Home</b>			4b. City, Town, or Location of Death <b>Grantsville</b>			4c. County of Death <b>Garrett</b>			
Funeral Director	5. Social Security Number <b>175-24-2392</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>July 9, 1921</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	10a. State <b>PA</b>		10b. County <b>Somerset</b>	10c. City, Town or Location <b>West Salisbury</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>610 Tub Mill Run Rd.</b>				10f. Zip Code <b>15565</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1946</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify:		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>			16b. Kind of Business/Industry <b>textiles</b>					
17. Father's Name (First, Middle, Last) <b>George Keim</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Edna May Bodes</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Virginia Rissmiller/Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>610 Tub Mill Run Rd., West Salisbury, PA 15565</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Newman</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Country Side Crematory Sept. 12, 2006 Davidsville, PA</b>			Date	20c. Location - City or Town, State <b>Newman Funeral Home, Inc. P.O. Box 116, Salisbury, PA 15558</b>				
21. Signature of Funeral Service Licensee <b>► Newman</b>					22. Name and Address of Facility <b>Newman Funeral Home, Inc. P.O. Box 116, Salisbury, PA 15558</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Atherosclerotic cardiovascular disease.</b>					Approximate Interval Between Onset and Death <b>6 months</b>					
<b>a.</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
					<b>M</b>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number <b>D0055325</b>					
29b. Signature and title of certifier <b>► WONSOOK SHIN MD</b>					29d. Date signed (Month, Day, Year) <b>Sep 11, 2006</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WONSOOK SHIN MD 48 Tawn Terrace Frostburg MD 21532</b>										
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>					32. Registrar's Signature <b>► J. A. [Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-instrument.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30534

Reg. No.

1- For  
State  
Registrar

<p><b>Physician /Medical Examiner</b></p> <p><b>Funeral Director</b></p> <p><b>To Be Completed by Funeral Director</b></p> <p>Baltimore, Maryland 21215-0036</p> <p>Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</p>	<p>1. Decedent's Name (First, Middle, Last) <b>Harold Wilson Hoffman</b></p> <p>4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b></p> <p>5. Social Security Number <b>218-10-2431</b></p> <p>6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b></p> <p>7. Age (In yrs. last birthday) <b>90 Yrs.</b></p> <p>4b. City, Town, or Location of Death <b>Frederick</b></p> <p>2. Date of Death Month <b>September</b> Day <b>8</b> Year <b>2006</b></p> <p>3. Time of Death <b>9:28 AM</b></p> <p>4c. County of Death <b>Frederick</b></p> <p>4d. Usual Residence of Decedent 10a. State <b>Maryland</b></p> <p>10b. County <b>Frederick</b></p> <p>10c. City, Town or Location <b>Frederick</b></p> <p>10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b></p> <p>10e. Street and Number <b>7956 McKaig Road</b></p> <p>10f. Zip Code <b>21701</b></p> <p>10g. Citizen of What Country? <b>United States</b></p> <p>11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b></p> <p>12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b></p> <p>If Yes, Give Year or Dates: <b>Specify:</b></p> <p>13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b></p> <p>If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>Specify: White</b></p> <p>14. Race - American Indian, Black, White, etc.</p> <p>15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b></p> <p>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b></p> <p>16b. Kind of Business/Industry <b>Department of the Navy</b></p> <p>17. Father's Name (First, Middle, Last) <b>Charles Hoffman</b></p> <p>18. Mother's Name (First, Middle, Maiden Surname) <b>Dessie Fox</b></p> <p>19a. Informant's Name/Relationship (Type, Print) <b>Nancy Hoffman / Wife</b></p> <p>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7956 McKaig Road, Frederick, MD 21701</b></p> <p>20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b></p> <p>20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b></p> <p>Date <b>Sept. 9, 2006</b></p> <p>20c. Location - City or Town, State <b>Baltimore, Maryland</b></p> <p>21. Signature of Funeral Director/Licensee </p> <p>22. Name and Address of Facility <b>Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701</b></p> <p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myocardial Infarction</b></p> <p>Due to (or as a consequence of): <b>Specify:</b></p> <p>23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Specify:</b></p> <p>23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b></p> <p>23d. Date of delivery Month <b>Day</b> <b>Year</b></p> <p>23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b></p> <p>24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b></p> <p>24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b></p> <p>25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b></p> <p>Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b></p> <p>26. Place of Death (Check only one) <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b></p> <p>27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b></p> <p>28a. Date of Injury (Month, Day Year) <b>Specify:</b></p> <p>28b. Time of Injury <b>Specify:</b></p> <p>28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b></p> <p>28d. Describe how injury occurred <b>Specify:</b></p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Specify:</b></p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Specify:</b></p> <p>29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b></p> <p>29b. Signature and title of certifier </p> <p>29c. License number <b>D-13971</b></p> <p>29d. Date signed (Month, Day, Year) <b>9/8/06</b></p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert L. Kaufmann, M.D. 300 West 9th St. Frederick, MD 21701</b></p> <p>31. Date filed (Month, Day, Year) <b>SEP 11 2006</b></p> <p>32. Registrar's Signature </p>						
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**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified.

Baltimore, Maryland 21215-0036

**Medical Certification: To Be Completed by Physician/Medical Examiner**

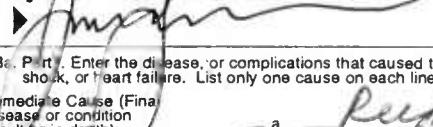
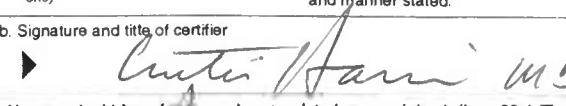
To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene  
**Certificate of Death**

2006 30535  
 Reg. No.

1- For  
State  
Registrar

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Arnold C. Hepworth</b>						2. Date of Death Month Day Year <b>September 7 2006</b>	3. Time of Death <b>4:50 a M</b>
	4a. Facility Name (If not institution, give street and number) <b>3406 Saratoga Avenue</b>			4b. City, Town, or Location of Death <b>Annapolis</b>			4c. County of Death <b>Anne Arundel</b>	
<b>Funeral Director</b>	5. Social Security Number <b>103-22-5821</b>	6. Sex <b>1 X M 2 □ F</b>	7. Age (In yrs. last birthday) <b>79 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Oct 29 1926</b>	9. Birthplace (State or Foreign Country) <b>Japan</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <b>1 □ Yes 2 X No</b>				
10e. Street and Number <b>3406 Saratoga Avenue</b>				10f. Zip Code <b>21403</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: <b>WWII</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>5+</b>			16b. Kind of Business/Industry <b>Salesman</b> <b>Real Estate</b>			
17. Father's Name (First, Middle, Last) <b>Thomas P. Hepworth</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Griffith</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Paula Hepworth (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3406 Saratoga Avenue, Annapolis, MD 21403</b>				
20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>			Date <b>9-8-2006</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hardesty Funeral Home, P.A.</b> <b>12 Ridgely Avenue, Annapolis MD 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last								
<p>a. <b>Respiratory Failure</b> Due to (or as a consequence of):</p> <p>b. <b>Lung Cancer</b> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown								
25. Was case referred to medical examiner? 1 □ Yes 2 □ No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)						
27. Manner of Death 1 □ Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>053306</b>						
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>9/7/06</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Curtis Harris, MD 800 Bestgate Rd Ste 300 Annapolis MD 21401</b>								
31. Date filed (Month/Day, Year) <b>SEP 11 2006</b>		32. Registrar's Signature 						

ORIGINAL

06-06811

Hector Abilio Lainez

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30536

1. For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last) <b>HECTOR ABILIO LAINEZ JANDRES</b>				2. Date of Death Month Day Year September 9, 2006	3. Time of Death 2053 hrs
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**Funeral  
Director**

4a. Facility Name (if not institution, give street and number) <b>Shady Grove Adventist Hospital</b>			4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>213-29-5448</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>36 Yrs.</b>	If Under 1 Year Months <b>36</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (MM/DD/YYYY) <b>March/23/1970</b>	9. Birthplace (State or Foreign Country) <b>EL SALVADOR</b>

8/21/21  
 Baltimore, MD 21215-0036  
 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Germantown</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>14017 Jump Drive (house)</b>			10f. Zip Code <b>20878</b>		10g. Citizen of What Country? <b>EL SALVADOR</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No specify: <b>EL SALVADORIAN</b>			14. Race - American Indian, Black, White, etc. Specify: <b>AMERICAN INDIAN</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COOK</b>			16b. Kind of Business/Industry <b>RESTAURANT</b>	

17. Father's Name (First, Middle, Last) <b>PRUDENCIO JANDRES</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>ISABEL LAINEZ</b>
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19a. Informant's Name/Relationship (Type, Print) <b>NOHEMY ISABEL LAINEZ (WIFE)</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14017 Jump Drive, GERMANTOWN, MD 20878</b>
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20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cemetery: San Rafael Barrios</b>	Date <b>09/29/06</b>	20c. Location - City or Town, State <b>EL CALVARIO, SAN SALVADOR.</b>
21. Signature of Funeral Service Licensee <i>David J. Titus</i>	22. Name and Address of Facility <b>SANTA CRUZ FUNERALES LATINOS, INC.</b> <b>600 KENNEDY Street; N.W. WASHINGTON, D.C. 20011</b>		

**Physician/  
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. Acute anterior myocardial infarction</b>		
Due to (or as a consequence of):		
b. Diffuse coronary arteries		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

<input checked="" type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED item#1,23a-b,27,perME,g860, 10/18/06 TT	23c. If yes, outcome of pregnancy	23d. Date of delivery
		<input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown	Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one)		
	Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other:	

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>J.M. Titus</i>	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 10, 2006</b>
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30. Name and address of person who completed cause of death (Item 23a) <b>Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>
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31. Date filed (Month, Day, Year) <b>SEP 21 2006</b>	32. Registrar's Signature <i>James B. Aponte</i>
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Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Anthony Andrew Johnson

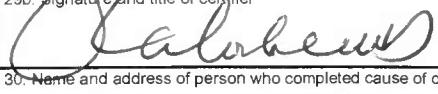
**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**Reg. No. **2006 30537**1- For State  
Registrar**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director****Physician  
/Medical  
Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

Baltimore, MD 21215-0036  
 Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death		
<b>Anthony Andrew Johnson</b>		<b>September 4, 2006</b>				0757 hrs		
4a. Facility Name (if not institution, give street and number) <b>1911 Brooks Drive</b>		4b. City, Town, or Location of Death <b>Upper Marlboro</b>				4c. County of Death <b>Prince George's</b>		
5. Social Security Number <b>577-88-5486</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>34</b>	Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) <b>04-04-1972</b>	9. Birthplace (State or Foreign Country) <b>D.C.</b>
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Capitol Heights</b>				10d. Inside City Limits <b>1 Yes 2 No</b>	
10e. Street and Number <b>1101 Dutton Way</b>		10f. Zip Code <b>20743</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <b>1 Never Married 2 Married</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Towing Business</b>		16b. Kind of Business/Industry <b>Private</b>				
17. Father's Name (First, Middle, Last) <b>Charles S. Johnson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Shearrell Cole</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Shearrell Cole/mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2752 Marlette Place Waldorf, Maryland 20601</b>						
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lincoln Mem. Cemetery</b>		Date <b>09-15-06</b>	20c. Location - City or Town, State <b>Suitland, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Mary E. Hedgeman MO 1374</b>		22. Name and Address of Facility <b>Cedar Hill FH 4111 PA Ave. Suitland, MD 20746</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a Multiple Gunshot Wounds</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  <b>UNPENDED</b> <b>AMENDED</b>								
23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy</b> <b>4 Pregnant at time of death 5 Other (Specify)</b> <b>9 Unknown</b>				23d. Date of delivery Month Day Year		
23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>								
24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>						
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other: Scene</b>						
27. Manner of Death <b>1 Natural 5 Pending Investigation</b> <b>2 Accident 6 Could not be determined</b> <b>3 Suicide 7</b> <b>4 Homicide 8</b>		28a. Date of Injury (Month, Day, Year) <b>Sep 4, 2006</b>		28b. Time of Injury <b>0718 hrs</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>(Specify) Woods</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1911 Brooks Drive, Upper Marlboro, MD</b>				
29a. Certifier <b>1 Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Check only one). <b>2 Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>September 5, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) <b>Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>								
31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature 						

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

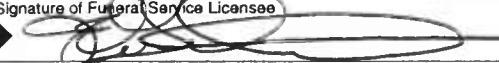
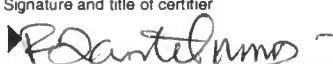
State of Maryland / Department of Health and Mental Hygiene

2006 30538

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Morris KRAVITZ</b>						2. Date of Death Month Day Year <b>September 9, 2006</b>		3. Time of Death 9:20 P M	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>577-14-3267</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 14, 1914</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent		10a. State <b>Maryland</b> 10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>10703 Huntwood Drive</b>			10f. Zip Code <b>20901</b>			10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>4</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>				16b. Kind of Business/Industry <b>Accounting</b>		
17. Father's Name (First, Middle, Last) <b>Isadore Kravitz</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Reva Goldberg</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Kravitz, Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10703 Huntwood Drive, Silver Spring, MD 20901</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Judean Memorial Gardens</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>09/12/06</b>	20c. Location - City or Town, State <b>Olney, MD</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Torchinsky Hebrew Funeral Home</b> <b>254 Carroll St., NW, Washington, DC 20012</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Cellulitis</b> Due to (or as a consequence of):  <b>b. Sepsis</b> Due to (or as a consequence of):  <b>c. </b> Due to (or as a consequence of):  <b>d. </b>								Approximate Interval Between Onset and Death	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number <b>D 0061768</b>					
29b. Signature and title of certifier 					29d. Date signed (Month, Day, Year) <b>September 10, 2006</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Fabianne Santel, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910</b>					32. Registrar's Signature 					
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or if Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

24

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30539  
Reg. No.

1- For  
State  
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Alexander Kenney</b>							2. Date of Death Month Day Year <b>September 4, 2006</b>	3. Time of Death <b>7:45 P M</b>			
	4a. Facility Name (If not institution, give street and number) <b>Charlotte Hall Veteran's Home</b>			4b. City, Town, or Location of Death <b>Charlotte Hall</b>			4c. County of Death <b>St. Mary's</b>					
Funeral Director	5. Social Security Number <b>180-12-1017</b>	6. Sex <b>1 X M 2 □ F</b>	7. Age (In yrs. last birthday) <b>83 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>5/22/1923</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Queen Anne's</b> 10c. City, Town or Location <b>Stevensville</b>									10d. Inside City Limits <b>1 □ Yes 2 X No</b>		
	10e. Street and Number <b>102 Beachside Drive</b>				10f. Zip Code <b>21666</b>			10g. Citizen of What County? <b>USA</b>				
	11. Marital Status <b>1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 □ No If Yes, Give Year or Dates: <b>1942-46</b></b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 □ Yes 2 X No</b> Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>12th</b> <b>Electronics Engineer</b>			16b. Kind of Business/Industry <b>NASA</b>						
	17. Father's Name (First, Middle, Last) <b>Robert A. Kenney, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Amelia Morauer</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Donna K. Essick/ Daughter</b>											
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13 Woodward Court, Annapolis, Maryland 21403</b>											
	20a. Method of Disposition <b>1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>			Date <b>9-8-06</b>	20c. Location - City or Town, State <b>Crownsville, MD</b>						
	21. Signature of Funeral Service Licensee <b>Robert A. Kenney</b>											
	22. Name and Address of Facility <b>George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037</b>											
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypernatremia</b> Due to (or as a consequence of):  Also list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Urinary tract infection</b> Due to (or as a consequence of):  <b>c. Atrial Fibrillation</b> Due to (or as a consequence of):  <b>d. Ischemic cardiomyopathy</b>									Approximate Interval Between Onset and Death		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 □ No 9 □ Unknown</b>	23c. If yes, outcome of pregnancy <b>1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown</b>			23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Anemia of Chronic disease</b> <b>Subtotal gastrectomy with gastrojejunostomy</b> <b>Chronic Anticoagulation with Warfarin</b>									23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown</b>		
	25. Was case referred to medical examiner? <b>1 □ Yes 2 X No</b>	Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA			Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)	26. Place of Death (Check only one)						
	27. Manner of death <b>1 X Natural 2 □ Accident 3 □ Suicide 4 □ Homicide</b>	5 □ Pending investigation 6 □ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>											
	29b. Signature and title of certifier <b>► John J. Kaufman</b>				29c. License number <b>N 2906</b>			29d. Date signed (Month, Day, Year) <b>9/15/06</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LOUIS KAUFMAN 8926 Woodyard Road suite 602 Clinton, Maryland 20735</b>											
	31. Date filed (Month, Day, Year) <b>SEP 08 2006</b>	32. Registrar's Signature <b>John J. Kaufman</b>										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important! If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**Reg. No. **2006 30540**1- For State  
Registrar**Physician/  
Medical Examiner****Funeral  
Director**

Baltimore, MD 21215-0036  
 Permit Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director****Medical Certification: To Be Completed by Physician/Medical Examiner****Division of Vital Records, P.O. Box 68760,**

Within 24 hours after death

To the Hospital or Attending Physician: The law requires that the death certificate be executed completely filled in by the funeral director; page 2 should be detached for use as the burial - transit

1. Decedent's Name (First, Middle, Last) <b>Earline Lee</b>		2. Date of Death Month <b>September</b> Day <b>7</b> Year <b>2006</b>		3. Time of Death <b>2149 hrs</b>
4a. Facility Name (if not institution, give street and number) <b>Prince George's Hospital Center</b>		4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince George's</b>
5. Social Security Number <b>577-98-3730</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>29</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	8. Date of Birth (MM/DD/YYYY) <b>July 29, 1977</b>
9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State <b>D.C.</b>		10b. County		10c. City, Town or Location <b>Washington</b>
10e Street and Number <b>2806 Alabama Avenue, S.E. Apt. #3</b>		10f Zip Code <b>20019</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: Specify: <b>Black</b>	14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unemployed</b>		16b. Kind of Business/Industry <b>N/A</b>
17. Father's Name (First, Middle, Last) <b>Earl Jones</b>		18 Mother's Name (First, Middle, Maiden Surname) <b>Janie Trent</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Janie Lee (Mother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4702 Bass Place, S.E. Washington, D.C. 20019</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery</b>		Date <b>09-19-2006</b>
21. Signature of Funeral Service Licensee <b>Sandy C. Anderson</b>		22. Name and Address of Facility <b>Rollins Funeral Home, Inc. 4339 Hunt Pl. NE Washington, DC 20019</b>		
25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. <b>End stage renal disease</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED item#23a,27,perME,g859,9/27/06 TT				
23b. IF FEMALE. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				
23d. Date of delivery Month _____ Day _____ Year _____				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Suicide		28a. Date of Injury (Month, Day, Year) <b>(Specify)</b>	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc.		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29c. License number <b>O.C.M.E.</b>		
29b. Signature and title of certifier <b>Carol Allan, MD Assistant Medical Examiner</b>		29d. Date signed (Month, Day, Year) <b>September 9, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) <b>Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>		31. Date filed (Month, Day, Year) <b>SEP 22 2006</b>		
32. Registrar's Signature <b>Leanne &amp; Janie</b>		33. Original		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30541

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES LUMPKIN</b>							2. Date of Death Month Day Year <b>SEPTEMBER 10 2006</b>	3. Time of Death <b>10:34A</b>
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGE'S HOSPITAL</b>			4b. City, Town, or Location of Death <b>CHEVERLY</b>			4c. County of Death <b>PRINCE GEORGE'S</b>		
Funeral Director	5. Social Security Number <b>252-16-2925</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>90 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>MAY 27 1916</b>	9. Birthplace (State or Foreign Country) <b>FLORIDA</b>	
	Usual Residence of Decedent		10a. State <b>MD</b> 10b. County <b>PRINCE GEORGE'S</b> 10c. City, Town or Location <b>FAIRMONT HEIGHTS</b>			10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			
To Be Completed by Funeral Director	10e. Street and Number <b>5607 JEFFERSON HEIGHTS DRIVE</b>			10f. Zip Code <b>20743</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>Army</b> <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> If Yes, Give Year or Dates: <b>6/42-1/46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>BLACK</b> Specify:	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) PRESSER</b>		16b. Kind of Business/Industry <b>PRIVATE</b>				
	17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>EUNICE COX</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>REGINA LUMPKIN/DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5702 READING AVE # 72 ALEXANDRIA, VIRGINIA 22311</b>					
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND VETERANS</b>			Date <b>9/18/2006</b>	20c. Location - City or Town, State <b>CHELTHAM, MARYLAND</b>	
	21. Signature of Funeral Service Licensee <b>K. D. Hall</b>			22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>FATAL CARDIAC ARRHYTHMIA</b> Due to (or as a consequence of): b. Due to (or as a consequence of). c. Due to (or as a consequence of). d.								
	Approximate Interval Between Onset and Death								
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>								
	24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>					
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>								
	26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>								
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day Year) <b>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>								
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>								
	29b. Signature and title of certifier <b>29c. License number <b>D58951</b></b>								
	29d. Date signed (Month, Day, Year) <b>9-12-06</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHEVERLY, MD 20785</b>								
	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>								
	32. Registrar's Signature <b>Heidi A. Spatz</b>								

Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Amended item 19a per  
Funeral Director, 9/14/06; CS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

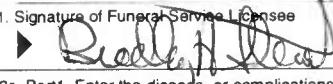
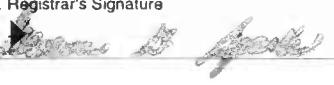
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30542

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frances Elizabeth Lickliter</b>							2. Date of Death Month Day Year <b>Sept. 14, 2006</b>	3. Time of Death <b>3:20 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>Dennett Road Manor Nursing Home</b>			4b. City, Town, or Location of Death <b>Oakland</b>			4c. County of Death <b>Garrett</b>		
Funeral Director	5. Social Security Number <b>218-36-9135</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Mar. 19, 1915</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Garrett</b>			10c. City, Town or Location <b>Mountain Lake Park</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>607 N Street, Apt. 9</b>			10f. Zip Code <b>21550</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>			16b. Kind of Business/Industry <b>Arcade</b>		
17. Father's Name (First, Middle, Last) <b>Roy A. Long</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Florence W. Wilson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Wakefield Friend Shirley Wakefield Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>54 E. Ashby-Ellis Road, Oakland, Maryland 21550</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Moreland Memorial Pk.</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>9/18/2006</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stewart Funeral Home 32 S. Second St. Oakland, MD 21550</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Coronary Artery Disease</b>								Approximate Interval Between Onset and Death <b>Years</b>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Arteriosclerotic Cardiovascular Heart Disease</b>								Approximate Interval Between Onset and Death <b>Years</b>
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 					
				29c. License number <b>D15333</b>			29d. Date signed (Month, Day, Year) <b>9/14/2006</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550</b>				31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>					
				32. Registrar's Signature 					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30543

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sally Stevens Larkin</b>							2. Date of Death Month Day Year <b>September 10 2006</b>	3. Time of Death 3:31 P M
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Frederick</b>			4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>218-34-3561</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 12, 1937</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Frederick</b> 10c. City, Town or Location <b>Frederick</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
	10e. Street and Number <b>510 Culler Avenue</b>			10f. Zip Code <b>21701</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Care Giver</b>			16b. Kind of Business/Industry <b>Health Department</b>		
	17. Father's Name (First, Middle, Last) <b>Clarence Grayson Stevens</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Rice</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Walter B. Larkin, Jr. / Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>510 Culler Avenue, Frederick, Maryland 21701</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Mem. Gardens</b>			Date <b>9/14/06</b>	20c. Location - City or Town, State <b>Frederick, Maryland</b>
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.</b> <b>1201 NORTH MARKET ST., FREDERICK, MD 21701</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pulmonary Embolus</b> Approximate Interval Between Onset and Death <b>Hours</b>								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IF FEMALE: 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								
	29c. License number <b>D54616</b>								
	29d. Date signed (Month, Day, Year) <b>September 10 2006</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHAWN BURK 310 West NINTH ST Frederick MD 21701</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 						

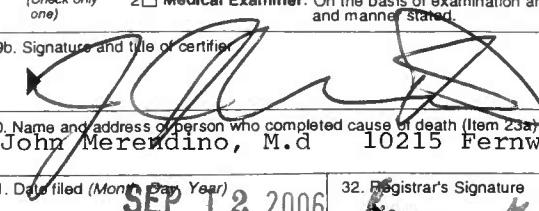
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2006 30544

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Conrad Mears, Jr.</b>							2. Date of Death Month Day Year <b>September 10, 2006</b>	3. Time of Death 12:10 PM		
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>219-82-4965</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Oct. 4, 1955</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>			
	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>1500 E. Randolph Road</b>				10f. Zip Code <b>20904</b>			10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 5</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Never Worked</b>				16b. Kind of Business/Industry <b>None</b>			
17. Father's Name (First, Middle, Last) <b>John Conrad Mears, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Jeanette Young</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Jeanette Kyle/Mother</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2700 Bellmawr Court, Silver Spring, MD 20906</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Gate of Heaven Cemetery</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>			Date <b>September 13, 2006</b>	20c. Location - City or Town, State <b>Silver Spring, Maryland</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901</b>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death Months		
Immediate Cause (Final disease or condition resulting in death) <b>Bilateral Vocal Cord Paralysis</b> Due to (or as a consequence of): <b>Viral Encephalopathy</b>									years		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
a. Due to (or as a consequence of): <b>Viral Encephalopathy</b>											
b. Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. _____											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure Disorder, Neuro-Muscular Dysphagia</b>										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one)	
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA										Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29d. Date signed (Month, Day, Year) <b>September 11, 2006</b>	
29b. Signature and title of certifier 										29c. License number <b>D36046</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Merendino, M.d 10215 Fernwood Road, Bethesda, MD 20817</b>											
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>					32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

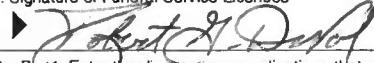
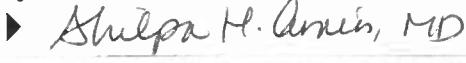
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30545

1- Amend #1 Per Phy G860 10/12/06 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death		
	Ruby Meacham Ruby Meacham							September 9, 2006	11:40pm <sup>M</sup>		
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death			
	Hebrew Home of Greater Washington				Rockville			Montgomery			
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 295-44-6438 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F 93 Yrs.											
If Under 1 Year If Under 24 Hrs. Months Days Hours Min.											
8. Date of Birth (Month, Day, Year) Mar 9, 1913											
9. Birthplace (State or Foreign Country) West Virginia											
Usual Residence of Decedent											
10a. State		10b. County		10c. City, Town or Location						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Maryland		Montgomery		Gaithersburg							
10e. Street and Number				10f. Zip Code						10g. Citizen of What Country? United States	
135 Timberbrook Lane				20878							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: White			14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Jacob Franklin Anderson					18. Mother's Name (First, Middle, Maiden Surname) Mary Laverne Soles						
19a. Informant's Name/Relationship (Type, Print) Judith Harley (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Timberbrook Lane, Gaithersburg, MD 20878						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) East Lake Cemetery			Date	20c. Location - City or Town, State North Kingsville, Ohio		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)										Approximate Interval Between Onset and Death	
a. Respiratory Decline Due to (or as a consequence of):											
b. Metastatic Colon Cancer Due to (or as a consequence of):										Unknown	
c. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Secondary Metastatic Disease to Liver, Peritoneum and Abdomen Coronary Artery Disease										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 					29c. License number D0052713			29d. Date signed (Month, Day, Year) September 10, 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shilpa H. Amin, MD, 6121 Montrose Road, Rockville, MD 20852											
31. Date filed (Month, Day, Year) SEP 12 2006					32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

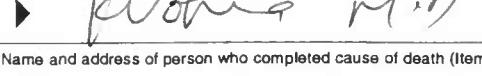
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Legible  
2006 30546

## *Certificate of Death*

Reg. No.

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Mary Alta McDonald</b>						2. Date of Death Month Day Year <b>September 5, 2006</b>		3. Time of Death <b>5:45 A.M.</b>	
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>Manor Care of Potomac</b>			4b. City, Town, or Location of Death <b>Potomac</b>			4c. County of Death <b>Montgomery</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>579-28-0448</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>100 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>July 21, 1906</b>	9. Birthplace (State or Foreign Country) <b>PA.</b>		
		Usual Residence of Decedent <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number <b>14613 Woodcrest Drive</b>			10f. Zip Code <b>20853</b>			10g. Citizen of What Country? <b>United States</b>			
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.		
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Telephone Operator</b>			16b. Kind of Business/Industry <b>Phone Company</b>			
		17. Father's Name (First, Middle, Last) <b>Felix Jacob Bradley</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Jane Hoover</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>Carol L. Redmond/Niece</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14613 Woodcrest Drive, Rockville, Maryland 20853</b>						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Resurrection Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>9/8/2006</b>		Date	20c. Location - City or Town, State <b>Clinton, Maryland</b>				
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>DeVol Funeral Home</b>			23. Approximate Interval Between Onset and Death			
					<b>10 East Deer Park Dr., Gaithersburg, MD. 20877</b>						
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
		Immediate Cause (Final disease or condition resulting in death) <b>a. Colon Cancer</b> Due to (or as a consequence of):									
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Recurrent Pneumonia</b> Due to (or as a consequence of): <b>c. Failure to Thrive</b> Due to (or as a consequence of): <b>d. Breast Cancer</b>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No									
		28d. Describe how injury occurred									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier 									
		29c. License number <b>D 20274</b>									
		29d. Date signed (Month, Day, Year) <b>September 5, 2006</b>									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kirti Vohra, M.D., 7710 Bradley Blvd., Bethesda, Maryland 20817</b>									
		31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>									
		32. Registrar's Signature 									

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner**

**1- For  
State  
Registrar**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30547

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
HELEN JUNE MOSER	September 13 2006	0750 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WASHINGTON COUNTY HOSPITAL	HAGERSTOWN	WASHINGTON

Funeral  
Director

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 2, 1916	9. Birthplace (State or Foreign Country) MARYLAND
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To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important! If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
MARYLAND	WASHINGTON	FUNKSTOWN	

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
30 WEST MAPLE STREET	21734	U.S.A.

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DENTAL ASSISTANT	16b. Kind of Business/Industry DENTIST OFFICE
--	--	--

17. Father's Name (First, Middle, Last) THEODORE E. WOLFORD	18. Mother's Name (First, Middle, Maiden Surname) MARTHA IRENE KERSHNER
--	--

19a. Informant's Name/Relationship (Type, Print) THOMAS E. MOSER SR./SON	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11907 PEACOCK TRAIL, HAGERSTOWN, MARYLAND 21742
---	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) REST HAVEN CEMETERY	Date 9/16/2006	20c. Location - City or Town, State HAGERSTOWN, MARYLAND
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21. Signature of Funeral Service Licensee ► Paul M. Dean	22. Name and Address of Facility BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713
---	--

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Approximate Interval Between Onset and Death 1-2 DAYS
a. Congestive heart failure Due to (or as a consequence of):	b. Cancer neck/larynx Due to (or as a consequence of):	c. Coronary Artery Disease Due to (or as a consequence of):
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
---	---	--	--	--	--

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
				28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
--

29b. Signature and title of certifier ► Helen June Moser	29c. License number D46561	29d. Date signed (Month, Day, Year) Sept. 13, 2006
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gelfman & Son 1190 Mt. Aetna Road Hagerstown MD 21740
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31. Date filed (Month, Day, Year) SEP 15 2006	32. Registrar's Signature Helen June Moser
--	---

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

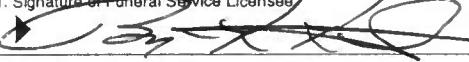
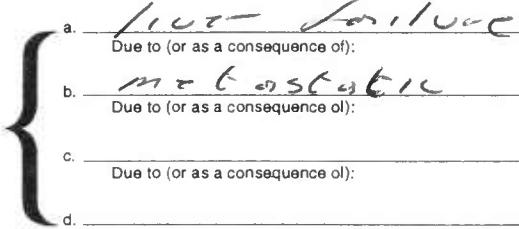
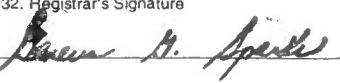
State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30548  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Tom Albert Myers</b>							2. Date of Death Month Day Year <b>Sept. 11 2006</b>	3. Time of Death <b>10:18 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>1401 The Terrace</b>			4b. City, Town, or Location of Death <b>Hagerstown</b>			4c. County of Death <b>Washington</b>					
Funeral Director	5. Social Security Number <b>272-38-1115</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>65 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>01/19/1941</b>	9. Birthplace (State or Foreign Country) <b>OH</b>				
	Usual Residence of Decedent		10a. State <b>MD</b>			10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>		10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
To Be Completed by Funeral Director	10e. Street and Number <b>1401 The Terrace</b>			10f. Zip Code <b>21740</b>			10g. Citizen of What Country? <b>US</b>					
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 4 Management</b>		16b. Kind of Business/Industry <b>Retail</b>							
	17. Father's Name (First, Middle, Last) <b>Richard Victor Myers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Loretta Lucille Hasselschert</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Glenda L. Myers / Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1401 The Terrace, Hagerstown, MD 21740</b>								
	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>			Date <b>09/13/2006</b>	20c. Location - City or Town, State <b>Smithsburg, MD</b>				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740</b>								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   a. Due to (or as a consequence of): <b>Heart Failure</b> b. Due to (or as a consequence of): <b>Metastatic Colon Cancer</b> c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>3 mo 9 yrs</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)</b>				23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>			
									24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>									
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>											
	29b. Signature and title of certifier 		29c. License number <b>D14626</b>			29d. Date signed (Month, Day, Year) <b>Sept 13, 2006</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Michael Myers, 101 W 7th St, Frederick MD 21701</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30549

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth M. Moore</b>					2. Date of Death Month <b>Sept.</b> Day <b>6, 2006</b> Year	3. Time of Death 4:10 AM
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>			4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>426-50-9677</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
				8. Date of Birth (Month, Day, Year) <b>Jan. 22, 1929</b>		9. Birthplace (State or Foreign Country) <b>Mississippi</b>	
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>			
10e. Street and Number <b>130 Hearne Road Apt 712</b>			10f. Zip Code <b>21401</b>			10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Residential Management</b>			16b. Kind of Business/Industry <b>Housing</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Moore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Herley Campbell</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Linda Shields / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1109 Brice Drive Edgewater, Maryland 21037</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Quaker Burial Grounds</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>9/11/2006</b>	20c. Location - City or Town, State <b>West River, Maryland</b>
21. Signature of Funeral Service Licensee <b>Michael J. Moore</b>				22. Name and Address of Facility John M. Taylor Funeral Home, Inc <b>147 Duke of Gloucester St. Annapolis, MD 21401</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death) <b>RESPIRATORY FAILURE</b>							
Approximate Interval Between Onset and Death							
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. Due to (or as a consequence of): <b>SEPSIS</b></p> <p>b. Due to (or as a consequence of): <b>LEFT DOMINANT WALL ABSCESS</b></p> <p>c. Due to (or as a consequence of): <b>GALLSTONE PANCREATITIS</b></p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<b>ATRIAL FIBRILLATION</b>							
<b>MENINGOMA</b>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>J. Joseph Herbert MD</b>					
		29c. License number <b>D 043371</b>					
		29d. Date signed (Month, Day, Year) <b>9/6/06</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jerome Joseph Herbert MD</b>							
31. Date filed (Month, Day, Year) <b>SEP 08 2006</b>		32. Registrar's Signature <b>R. Smith</b>					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified. [Redacted]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30550

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

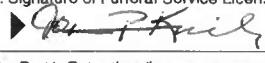
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Item 27 is marked other than "natural" or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Sarah Elizabeth Marlatt		September 5, 2006				2:20 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Crofton Convalescent Center		Crofton				Anne Arundel	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
146-36-6269			92 Yrs.		12/09/1913	West Virginia	
Usual Residence of Decedent						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State	10b. County	10c. City, Town or Location					
Maryland	Prince Georges	Bowie					
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?			
3608 Majestic Lane		20715		USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
Elementary/Secondary (0-12)	College (1-4 or 5+) 4	Nurse		Medical			
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)				
Earnest C. Patterson			Bertha Estelle Caw				
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Barbara E. Dathe/ Daughter			3608 Majestic Lane Bowie, MD 20715				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Huntt Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State Waldorf, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death years	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
{ a. <i>Cardiomyopathy</i> Due to (or as a consequence of):							
b. <i>Hypertensive Cardiovascular Disease</i> Due to (or as a consequence of):		years					
c. <i>Osteoarthritis</i> Due to (or as a consequence of):		years					
d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			M				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number					
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 9/6/06					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
Rakesh Arora, M.D. 14300 Gallant Fox Lane Suite 222 Bowie, MD 20715							
31. Date filed (Month, Day, Year) SEP 08 2006		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Items 23a per Dr., G860, 10/04/06 dd b  
Certificate of Death

2006 3055 |

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Pless Mannello</b>						2. Date of Death Month <b>September</b> Day <b>9</b> Year <b>2006</b>	3. Time of Death <b>9:30 AM</b>		
Funeral Director	4a. Facility Name (If not institution, give street and number) <b>Oakland Nursing and Rehabilitation Ctr.</b>			4b. City, Town, or Location of Death <b>Oakland</b>		4c. County of Death <b>Garrett</b>				
To Be Completed by Funeral Director	5. Social Security Number <b>215-14-5813</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Dec. 13 1921</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>MD</b>			10b. County <b>Garrett</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>706 E. Alder Street</b>			10f. Zip Code <b>21550</b>			10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Book Binder</b>			16b. Kind of Business/Industry <b>Publishing</b>			
	17. Father's Name (First, Middle, Last) <b>George Pless</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Susan Kieser</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Jim Cuppett, P.R.</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>706 E. Alder St., Oakland, MD 21550</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cumberland Crematory</b>			Date <b>9/14/06</b>	20c. Location - City or Town, State <b>Cumberland, MD</b>		
	21. Signature of Funeral Service Licensee <b>Katherine Sauer</b>			22. Name and Address of Facility <b>Burdock-Durst Funeral Home</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Dementia</b>			23b. Approximate Interval Between Onset and Death <b>15 years</b>						
	a. <b>aspiration of food</b> Due to (or as a consequence of):			23c. Approximate Interval Between Onset and Death <b>20 minutes</b>						
	b. <b>dysphagia</b> Due to (or as a consequence of):			23d. Approximate Interval Between Onset and Death <b>5 years</b>						
	c. <b>dementia</b> Due to (or as a consequence of):			23e. Approximate Interval Between Onset and Death <b>15 years</b>						
	d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Catatonic schizophrenia</b>			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
				23g. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			23h. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year) <b>1 1 06</b>	28b. Time of Injury M <b>1</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <b>Walter K. Naumann MD</b>	29c. License number <b>D0025759</b>						29d. Date signed (Month, Day, Year) <b>September 9, 2006</b>		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Walter K. Naumann MD, PO Box 247, Accident MD 21520</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>			32. Register's Signature <b>[Signature]</b>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30552

Reg. No.

For  
State  
Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Jacqueline Leigh Mumford</b>						2. Date of Death Month Day Year <b>September 7 2006</b>		3. Time of Death <b>D419 M</b>			
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>Peninsula Regional Medical Center</b>			4b. City, Town, or Location of Death <b>Salisbury</b>			4c. County of Death <b>Wicomico</b>					
To Be Completed by Funeral Director		5. Social Security Number <b>213-78-2400</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>5/30/1962</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
		Usual Residence of Decedent		10a. State <b>Maryland</b> 10b. County <b>Wicomico</b> 10c. City, Town or Location <b>Salisbury</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		10e. Street and Number <b>502 Emory Court</b>				10f. Zip Code <b>21804</b>			10g. Citizen of What Country? <b>USA</b>				
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) - Telemarketer</b>		16b. Kind of Business/Industry <b>Telemarketing</b>							
		17. Father's Name (First, Middle, Last) <b>George W. Bradford Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Carole Livingston Adkins</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Carole Adkins/mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6687 Quercus Dr., Hebron, MD 21830</b>									
		20a. Method of Disposition <input type="checkbox"/> Burial 1 <input type="checkbox"/> Cremation 2 <input type="checkbox"/> Removal from State 3 <input type="checkbox"/> Donation 4 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Grove Cemetery</b>		Date <b>9/12/06</b>			20c. Location - City or Town, State <b>Parsonsburg, MD</b>				
		21. Signature of Funeral Service Licensed		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>									
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
		<p>a. <b>Coronary Artery disease</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth 1 <input type="checkbox"/> Fetal death 2 <input type="checkbox"/> Ectopic pregnancy 3 <input type="checkbox"/> Pregnant at time of death 4 <input type="checkbox"/> Other (specify) 5 <input type="checkbox"/> Unknown 9						23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
		27. Manner of Death <input checked="" type="checkbox"/> Natural 1 <input type="checkbox"/> Pending investigation 5 <input type="checkbox"/> Accident 2 <input type="checkbox"/> Could not be determined 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No 2	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		29b. Signature and title of certifier 		29c. License number <b>D54807</b>						29d. Date signed (Month, Day, Year) <b>09-07-06</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAMESH AGARWAL, M.D. Peninsula Regional Medical Center 100 E. Calvert St. SALISBURY, MD.</b>											
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>		32. Registrar's Signature 									

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2006 30553

**1- For State Registrar**

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Ada P. Maiers</b>				2. Date of Death Month Day Year <b>September 17, 2006</b>	3. Time of Death 1602 hrs			
<b>Funeral Director</b>	4a. Facility Name (if not institution, give street and number) <b>Oldtown Rd. and Industrial Blvd.</b>				4b. City, Town, or Location of Death <b>Cumberland</b>				
<b>To Be Completed by Funeral Director</b>	5. Social Security Number <b>217-18-4309</b>		6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>83</b>	If Under 1 Year Months <b>Yrs</b>	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>9-19-1922</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>			10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
	10e. Street and Number <b>12620 Ruppenkamp Road</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>		
<b>Physician / Medical Examiner</b>	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> specify: <b>white</b>		14. Race - American Indian, Black, White, etc. <b>Specify: white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>			16b. Kind of Business/Industry <b>own home</b>	
	17. Father's Name (First, Middle, Last) <b>Charles Oster</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie (Boor) Oster</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Connie Edwards/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5001 Brook Haven Drive, Raleigh, NC 27612</b>					
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		Date <b>9-21-2006</b>	20c. Location - City or Town, State <b>Cumberland, MD</b>			
	21. Signature of Funeral Service Licensee <b>John Phum</b>				22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. 108 Virginia Avenue, Cumberland, MD 21502</b>				
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  <b>UNPENDED</b> <b>AMENDED</b>							Approximate Interval Between Onset and Death	
	23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>	
	25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene</b>						
	27. Manner of Death <b>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>Sep 17, 2006</b>		28b. Time of Injury <b>1535 hrs</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	28d. Describe how injury occurred <b>Driver auto auto collision</b>		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Major Road / Highway</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Oldtown Rd. and Industrial Blvd., Cumberland, MD</b>						
	29a. Certifier (Check only one) <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated</b>		29c. License number <b>O.C.M.E.</b>						
	29b. Signature and title of certifier <b>Pamela Southall, MD Assistant Medical Examiner</b>		29d. Date signed (Month, Day, Year) <b>September 18, 2006</b>						
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>SEP 26 2006</b>		32. Registrar's Signature <b>[Signature]</b>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30554

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death		
Otis Odell Moss		Sept. 21 2006				0550 M		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death		
SunBridge Care and Rehabilitation		Elkton				Cecil		
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03/22/1925	9. Birthplace (State or Foreign Country) Virginia	
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State MD	10b. County Harford	10c. City, Town or Location Havre de Grace				10g. Citizen of What Country? USA		
10e. Street and Number 3803 Moxley Road		10f. Zip Code 21078				14. Race - American Indian, Black, White, etc. Specify: White		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry U.S. Government
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		18. Mother's Name (First, Middle, Maiden Surname) Neva Williams		
17. Father's Name (First, Middle, Last) Dolphus W. Moss		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Lyric Dr., Newark, DE 19702				19a. Informant's Name/Relationship (Type, Print) Clifton Moss - Son		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Mem. Grdns.		20c. Location - City or Town, State Aberdeen, MD		Date 09/25/06		
21. Signature of Funeral Service Licensee Shirine m. Smith-Bishop		22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 23 S. Washington, Havre de Grace, MD 21078						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Dementia				Approximate Interval Between Onset and Death Years		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):						
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery disease		23g. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				23h. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Sachdev S MD		29c. License number D0023322		29d. Date signed (Month, Day, Year) 9.21.2006				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Sachdev MD, 118 North St Suite 3B Elkton MD 21921								
31. Date filed (Month, Day, Year) SEP 26 2006		32. Registrar's Signature Kew B. Hall						

State  
Registrar

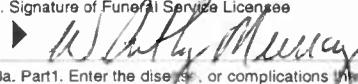
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30555  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Audrey Rout Nicholson</b>						2. Date of Death Month Day Year <b>Sept. 10, 2006</b>	3. Time of Death <b>3:30 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>10500 Rockville Pike #1620</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>213-50-6084</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Mar. 9, 1913</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>10500 Rockville Pike #1620</b>			10f. Zip Code <b>20852</b>			10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>John Rout</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mabelle Bond</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Thomas Nicholson/ Nephew</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>263 Congressional Lane #105 Rockville, MD 20852</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Rock Creek Cemetery</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rock Creek Cemetery</b>			Date <b>09/18/2006</b>	20c. Location - City or Town, State <b>Washington, DC</b>	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Joseph Gawler's Sons Inc. <b>5130 Wisconsin Ave. NW Washington, DC 20016</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure! List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b>					Approximate Interval Between Onset and Death <b>5 Days</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Cerebrovascular Accident</b> <b>Colon Cancer</b>					Approximate Interval Between Onset and Death <b>3 Weeks</b> <b>6 Months</b>			
a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Schizophrenia</b> <b>Hypothyroid</b>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>					28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, Maryland 21215-0036</b>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>D50030</b>			29d. Date signed (Month, Day, Year) <b>Sept. 11, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David G. Rogers MD 5530 Wisconsin Ave. #1400 Chevy Chase, MD 20815</b>								
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

4

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30556

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

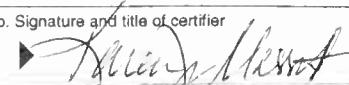
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner		Decedent's Name (First, Middle, Last)										2. Date of Death	3. Time of Death				
		Angelina H. NEAM										Month 09	Day 09	Year 06	2:40 PM		
Funeral Director		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death							4c. County of Death					
		RENAISSANCE GARDENS - RIDERWOOD NURSING HOME			SILVER SPRING							MONTGOMERY					
To Be Completed by Funeral Director		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)								
		579-28-1914		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	78 Yrs.	Months	Days	(Month, Day, Year)	WASHINGTON, DC	Hours	Min.	NOV. 9, 1927					
To Be Completed by Funeral Director		10a. State		10b. County		10c. City, Town or Location							10d. Inside City Limits				
		MARYLAND		MONTGOMERY		SILVER SPRING							1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director		10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?								
		3154 GRACEFIELD ROAD APT. 209				20904			UNITED STATES OF AMERICA								
To Be Completed by Funeral Director		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.								
		1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: WHITE								
To Be Completed by Funeral Director		15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry								
		Elementary/Secondary (0-12) 11				College (1-4 or 5+)			ADMINISTRATOR			FEDERAL GOVERNMENT					
To Be Completed by Funeral Director		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)											
		GAETANO BREDICE				TERESA DIANNI											
To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
		GEORGE NEAM - HUSBAND				3154 GRACEFIELD ROAD APT. 209, SILVER SPRING, MD 20904											
To Be Completed by Funeral Director		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date			20c. Location - City or Town, State								
		1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		GATE OF HEAVEN CEMETERY		09/13/06			SILVER SPRING, MARYLAND								
To Be Completed by Funeral Director		21. Signature of Funeral Service Licensee				22. Name and Address of Facility											
						HINES RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE, SILVER SPRING, MD 20904											
To Be Completed by Funeral Director		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death					
		Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):										≥ 2 weeks					
To Be Completed by Funeral Director		b. Due to (or as a consequence of):															
		c. Due to (or as a consequence of):															
		d. Due to (or as a consequence of):															
To Be Completed by Funeral Director		IF FEMALE:		23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy		23d. Date of delivery									
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)			Month	Day	Year						
To Be Completed by Funeral Director		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death?					
												1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
To Be Completed by Funeral Director		25. Was case referred to medical examiner?		26. Place of Death (Check only one)		24a. Was an autopsy performed?								24b. Were autopsy findings available prior to completion of cause of death?			
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director		27. Manner of Death		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred							
		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						M 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
To Be Completed by Funeral Director		29a. Certifier (Check only one)		29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)									
		1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				DOO43375		9/11/06									
To Be Completed by Funeral Director		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)		32. Registrar's Signature											
		3100 Gracefield Rd Silver Spring, MD 20904		SEP 12 2006													

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30557

1. For State  
Registrar

1 Decedent's Name (First, Middle, Last)

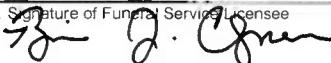
Andrew David Newman

2. Date of Death  
Month Day Year  
September 14, 20063. Time of Death  
1207 hrs**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director**

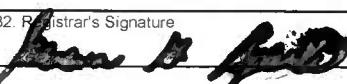
Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  
 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year September 14, 2006				3. Time of Death 1207 hrs	
Andrew David Newman								
4a. Facility Name (if not institution, give street and number) 756 Witneys Landing Road			4b. City, Town, or Location of Death Crownsville				4c. County of Death Anne Arundel	
5 Social Security Number 058-74-7382	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7 Age (in yrs last birthday) 18 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (MM/DD/YYYY) Sept 16 1987	9. Birthplace (State or Foreign Country) NY		
Usual Residence of Decedent 10a. State MD Anne Arundel			10c. City, Town or Location Crownsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 756 Whitneys Landing			10f. Zip Code 21032				10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:			14. Race - American Indian, Black, White, etc. Specify White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) College (1-4 or 5+) Student			16b. Kind of Business/Industry Education		
17. Father's Name (First, Middle, Last) Kevin Paul Newman			18. Mother's Name (First, Middle, Maiden Surname) Barbara Ann Erny					
19a. Informant's Name/Relationship (Type, Print) Kevin P. Newman (Father)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 756 Whitneys Landing, Crownsville, MD 21032					

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other Specify Entombment	20b. Place of Disposition (Name of cemetery, crematory or other place) St. Adalbert's Cem.	Date 9-20-2006	20c. Location - City or Town, State Lancaster, NY			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, MD 21054				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. Seizure disorder Due to (or as a consequence of):			Approximate Interval Between Onset and Death			
b. Due to (or as a consequence of):						
c. Due to (or as a consequence of):						
d. Due to (or as a consequence of):						
<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	item#23a,27,perME,g860, 10/17/06 TT				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred	

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) September 15, 2006
30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
31. Date filed (Month, Day, Year) SEP 21 2006	32. Registrar's Signature 			ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner****State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30558

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Martha Gray Outman</b>						2. Date of Death Month Day Year <b>September 9, 2006</b>	3. Time of Death <b>3:48 AM</b>						
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Prince Frederick</b>			4c. County of Death <b>Calvert</b>							
Funeral Director	5. Social Security Number <b>242-03-3180</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Feb 14, 1915</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Calvert</b> 10c. City, Town or Location <b>Chesapeake Beach</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
	10e. Street and Number <b>8421 D Street</b>			10f. Zip Code <b>20732</b>			10g. Citizen of What Country? <b>USA</b>							
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify:						
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) salesperson</b>		16b. Kind of Business/Industry <b>retail</b>									
	17. Father's Name (First, Middle, Last) <b>Wilbur Browning Gray</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Charlie Pearl Mingie</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>Tommie R. Outman, son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2320 Dalrymple Rd., Sunderland, MD 20689</b>				Date					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>So. Memorial Gardens</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>09-13-2006</b>				20c. Location - City or Town, State <b>Dunkirk, MD</b>					
	21. Signature of Funeral Service Licensee <b>Wilbur R. Gray</b>				22. Name and Address of Facility <b>Rausch Funeral Home, P.A., Owings, MD 20736</b>									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Stroke</b>								Approximate Interval Between Onset and Death					
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
	<p>a. Due to (or as a consequence of): <b>Stroke</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>													
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9 Unknown</b>				23d. Date of delivery Month Day Year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
											28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>110 Hospital Rd., Prince Frederick, MD 20618</b>		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>057949</b>				29d. Date signed (Month, Day, Year) <b>9/10/06</b>					
	29b. Signature and title of certifier <b>DR J. R. Gray</b>				32. Registrar Signature <b>James A. Spaulding</b>				31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>					

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30559

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Harlin William Parrish		September 11, 2006		2:40 AM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Calvert Memorial Hospital		Prince Frederick		Calvert
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 7, 1941
482-48-7058				9. Birthplace (State or Foreign Country) Iowa
Usual Residence of Decedent 10a. State MD		10b. County Calvert		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10c. City, Town or Location Huntingtown		10f. Zip Code 20639		10g. Citizen of What Country? USA
10e. Street and Number 4021 Starlight Court		10f. Zip Code 20639		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1962-65		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer
17. Father's Name (First, Middle, Last) Herbert		18. Mother's Name (First, Middle, Maiden Surname) Parrish Lola Ackerman		16b. Kind of Business/Industry Prince George's County Gov't
19a. Informant's Name/Relationship (Type, Print) Dorothy Jean Parrish		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4021 Starlight Court Huntingtown, MD 20639		19c. Date Sept 14
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Mem. Grdn.		20c. Location - City or Town, State Dunkirk, MD
21. Signature of Funeral Service Licensee Gary J. Goff		22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
<p>a. Due to (or as a consequence of): Respiratory Failure</p> <p>b. Due to (or as a consequence of): Coronary Lung.</p> <p>c. Due to (or as a consequence of): Smoking</p> <p>d.</p>				
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number MD / D0060638 29d. Date signed (Month, Day, Year) 9/11/06		
29b. Signature and title of certifier N. Mendonca				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAYANTARA MENDONCA		31. Date filed (Month, Day, Year) SEP 13 2006 32. Registrar's Signature Lorraine A. Spotts		
33. Location (Street and Number or Rural Route Number, City or Town, State) 110. HOSPITAL ROAD # 310 PRINCE FREDERICK MD 20678				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30560  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Owen Parker</b>							2. Date of Death Month Day Year <b>Sept 12 2006</b>	3. Time of Death 4:05 A M
	4a. Facility Name (If not institution, give street and number) <b>Solomons NURsing Center</b>				4b. City, Town, or Location of Death <b>Solomons</b>			4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>223-92-1735</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>99</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>June 30 1907</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>		
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Lusby</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>11977 Pine Trail</b>				10f. Zip Code <b>20657</b>				10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>				16b. Kind of Business/Industry <b>own home</b>	
17. Father's Name (First, Middle, Last) <b>William David Owen</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Nancy Watson Cheatham</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Hopkins- daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11977 Pine Trail Lusby MD 20657</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Brausch</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maury Cemetery</b>			Date <b>Sept 15 2006</b>	20c. Location - City or Town, State <b>Richmond Virginia</b>		
21. Signature of Funeral Service Licensee <b>Rausch</b>									
22. Name and Address of Facility <b>Rausch Funeral Home 4405 Broomes Is. rd. Port Republic MD 20676</b>									
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Post Traumatic Intracerebral Hemorrhage</b> Due to (or as a consequence of): b. _____ c. _____ d. _____ Approximate Interval Between Onset and Death									
23b. Part 2. Enter other diseases, or complications that contributed to the death but did not result in the underlying cause given in Part I. <b>Ventricular B2 Octency</b> 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Douglas J Tardio MD</b>									
29c. License number <b>247610</b>									
29d. Date signed (Month, Day, Year) <b>September 12, 2006</b>									
30. Name and address of person completed cause of death (Item 23a) (Type, Print) <b>David J. Tardio, MD 110 Hospital Dr. Prince Frederick MD 20678</b>									
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b> 32. Registrar's Signature <b>Barbara J. Tardio</b>									

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30561

Reg. No.

For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
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Important: If Item 27 is marked other than "natural", or items 28a or 28c show  
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once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1- For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Mary Anna Paddy</b>						2. Date of Death Month Day Year <b>September 10 2006</b>	3. Time of Death <b>3:36A M</b>		
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>			4b. City, Town, or Location of Death <b>Annapolis</b>			4c. County of Death <b>Anne Arundel</b>			
Funeral Director		5. Social Security Number <b>213-22-2271</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>81 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Jan. 1, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b>						10c. City, Town or Location <b>Crownsville</b>			10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
		10e. Street and Number <b>1463 Fairfield Loop Road</b>			10f. Zip Code <b>21032</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
		11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates: <b> </b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: <b> </b>	14. Race - American Indian, Black, White, etc. <b>White</b>						
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>				
		17. Father's Name (First, Middle, Last) <b>Thomas Augustus Phipps</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Catherine O'Neill</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>Ruth E. King, Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1463 Fairfield Loop Road, Crownsville, MD 21032</b>						
		20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Our Lady of Sorrows</b>			Date <b>09-14-2006</b>	20c. Location - City or Town, State <b>West River, MD</b>		
		21. Signature of Funeral Service Licensee <b>William R. Geor</b>			22. Name and Address of Facility <b>Rausch Funeral Home, P.A. Owings, MD 20736</b>						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Streptococcal bacteremia with septic shock</b>						Approximate Interval Between Onset and Death <b>&gt;1 day</b>			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b> </b>									
		a. Due to (or as a consequence of): <b> </b>									
		b. Due to (or as a consequence of): <b> </b>									
		c. Due to (or as a consequence of): <b> </b>									
		d. _____									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>acute myocardial infarction</b> <b>asplenia</b> <b>multiple myeloma</b>						23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>			
		25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>						26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>			
		27. Manner of death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day Year) <b> </b>		28b. Time of Injury <b> </b>		28c. Injury at Work? <b>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		28d. Describe how injury occurred <b> </b>	
		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b> </b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b> </b>					
		29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>						29d. Date signed (Month, Day, Year) <b>8-12-2006</b>			
		29b. Signature and title of certifier <b>Robert Peterson MD ATMC Annapolis MD 21401</b>						29c. License number <b>024809</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Peterson MD ATMC Annapolis MD 21401</b>									
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature <b>Bevans &amp; Associates</b>							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30562

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ellen Parker</b>						2. Date of Death Month Day Year <b>Sep 3, 2006</b>	3. Time of Death <b>1:40 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>1516 Pine Road</b>			4b. City, Town, or Location of Death <b>St. Leonard</b>			4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>214-74-1910</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jul 14, 1924</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Calvert</b> 10c. City, Town or Location <b>St. Leonard</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>1516 Pine Road</b>			10f. Zip Code <b>20685</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1946</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>		14. Race - American Indian, Black, White, etc.	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 3</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Own Home</b>	
	17. Father's Name (First, Middle, Last) <b>Jack Johnson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>LaChester Commodore</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>LaChester Mary Harris/ Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2255 Sixes Road Prince Frederick, MD 20678</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Greater Bible Way Church</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greater Bible Way Church</b>		Date <b>09/11/06</b>	20c. Location - City or Town, State <b>Prince Frederick, MD</b>	
	21. Signature of Funeral Service Licensee <b>► Gladys A. Sewell</b>			22. Name and Address of Facility <b>Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Melanoma</b> Approximate Interval Between Onset and Death <b>Weeks</b>							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							
	23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred M <input type="checkbox"/> Yes <input type="checkbox"/> No							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>► Gladys A. Sewell MD</b>							
	29c. License number <b>D0059061</b>							
	29d. Date signed (Month, Day, Year) <b>September 6, 2006</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>110 Hospital Road Suite 212 Prince Frederick MD 20678</b>							
	31. Date filed (Month, Day, Year) <b>SEP 6 2006</b>							
	32. Registrar's Signature <b>► Sean A. Parker</b>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

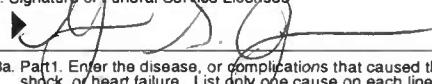
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30563

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Agatha Dolores Perry</b>							2. Date of Death Month Day Year <b>September 06, 2006</b>	3. Time of Death <b>12:55 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Casey House</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>131-20-5749</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Oct. 10, 1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Poolesville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>17431 Hoskinson Road</b>				10f. Zip Code <b>20837</b>			10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Caucasian</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>			16b. Kind of Business/Industry <b>Insurance</b>			
17. Father's Name (First, Middle, Last) <b>John Perry</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Warchol</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Accardi / Niece</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19690 Wooton Avenue; Poolesville, Maryland 20837</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Ft. Lincoln Crematory</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory</b>			Date <b>9/13/2006</b>	20c. Location - City or Town, State <b>Brentwood, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852</b>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Lung Cancer</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>									Approximate Interval Between Onset and Death	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b>									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>H0058032</b>					29d. Date signed (Month, Day, Year) <b>Sept. 7, 2006</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Cynthia M. Williams, D.O. 6001 Muncaster Mill Road; Rockville, Maryland 20850</b>										
31. Date filed (Month Day, Year) <b>SEP 12 2006</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30564

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edward Charles Pakulniewicz</b>							2. Date of Death Month Day Year <b>September 02, 2006</b>	3. Time of Death <b>05:00 aM</b>
	4a. Facility Name (If not institution, give street and number) <b>Casey House</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>140-28-4964</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>69 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Oct. 15, 1936</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
	Usual Residence of Decedent  10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Kensington</b>		
To Be Completed by Funeral Director	10e. Street and Number <b>10920 Connecticut Avenue #306</b>			10f. Zip Code <b>20895</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status  1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces?  1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  Caucasian		14. Race - American Indian, Black, White, etc.  Specify: <b>Caucasian</b>
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <b>Supervisor</b>			16b. Kind of Business/Industry  <b>Printing</b>		
	17. Father's Name (First, Middle, Last) <b>Leo Joseph Pakulniewicz</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Sophie Spulnick</b>			19a. Informant's Name/Relationship (Type, Print) <b>Kathleen Menold / Daughter</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  <b>11405 Cam Court; Kensington, Maryland 20985</b>			20a. Method of Disposition  1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  <b>M.S.J.</b>			Date	20c. Location - City or Town, State  <b>Brentwood, Maryland</b>		
21. Signature of Funeral Service Licensee  <b>M.S.J.</b>			22. Name and Address of Facility  <b>Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852</b>						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death	
Sequentially list conditions, only relating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			a. <u>Acute Septicemia</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>H0058032</b>			29d. Date signed (Month, Day, Year) <b>Sept 6, 2006</b>			
29b. Signature and title of certifier  <b>Cynthia M. Williams, D.O.</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  <b>Cynthia M. Williams, D.O. 6001 Muncaster Mill Road; Rockville, Maryland 20850</b>									
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>			32. Registrar's Signature  <b>Brian D. Jones</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30565  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
FRANCIS J. PALMER		09 08 2006		12:04 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
UNION HOSPITAL		ELKTON		CECIL	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	8. Date of Birth (Month, Day, Year) DEC 25, 1926	
222-14-2496			79	9. Birthplace (State or Foreign Country) Delaware	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State	10b. County	10c. City, Town or Location			
Maryland	Cecil	Elkton			
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?	
133 Cherry Tree Lane		21921		United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
Elementary/Secondary (0-12) 12		College (1-4 or 5+)	14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry Manufacturing		
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname) Clarence J. Palmer Mary Madden			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Palmer/Son 133 Cherry Tree Lane, Elkton, Maryland 21921			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glebe Cemetery	Date September 12, 2006	20c. Location - City or Town, State New Castle, Delaware	
21. Signature of Funeral Service Licensee ► Donald S. Hicks		22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of):</p> <p>b. CHRONIC KIDNEY DISEASE STAGE IV Due to (or as a consequence of):</p> <p>c. CONGESTIVE HEART FAILURE Due to (or as a consequence of):</p> <p>d.</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier ► M.D.		29c. License number D0064670	29d. Date signed (Month, Day, Year) SEPTEMBER 08, 2006		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
MONIQUE LEATT-UBUNAMA, M.D. 106 BOW ST. ELKTON, MD 21921					
31. Date filed (Month, Day, Year) SEP 12 2006		32. Registrar's Signature Leanne B. Aponte			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

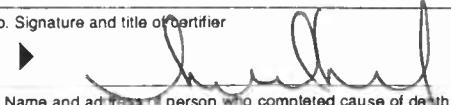
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30566

Reg. No.

1-  
For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert M. Preston</b>							2. Date of Death Month Day Year <b>September 12, 2006</b>	3. Time of Death <b>7:16A M</b>		
	4a. Facility Name (If not institution, give street and number) <b>12219 S. Debkay Court</b>			4b. City, Town, or Location of Death <b>Monrovia</b>			4c. County of Death <b>Frederick</b>				
Funeral Director	5. Social Security Number <b>578-22-2455</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Oct. 13, 1922</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Frederick</b> 10c. City, Town or Location <b>Monrovia</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	10e. Street and Number <b>12219 S. Debkay Court</b>			10f. Zip Code <b>21770</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Electrician</b>		16b. Kind of Business/Industry <b>Electrical</b>						
	17. Father's Name (First, Middle, Last) <b>James Preston</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ada Porteus</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Paula Preston - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12219 S. Debkay Court, Monrovia, Maryland 21770</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematorium</b>			Date <b>9/17/06</b>	20c. Location - City or Town, State <b>Alexandria, Virginia</b>				
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <b>Robert L. Williams</b>		22. Name and Address of Facility <b>Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872</b>								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
	<p>a. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):</p> <p>b. <b>VENTRICULAR FIBRILLATION</b>. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Medical Certification; To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) <b>9-13-06</b>		
	29b. Signature and title of certifier 								29c. License number <b>H0051280</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anushiravan Dadgar M.D. 9715 Medical Center Drive, Rockville, Maryland 20850</b>								31. Date filed (Month, Day, Year) <b>SEP 18 2006</b>		
	32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

STIVA  
9/13/06  
State Registrar

06-07099

Thelma Powell

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

2006 30567

Reg. No.

1. For State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Thelma Nancy Powell</b>					2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>	3. Time of Death 0325 hrs
	4a. Facility Name (if not institution, give street and number) <b>Peninsula Regional Medical Center</b>					4b. City, Town, or Location of Death <b>Salisbury</b>	4c. County of Death <b>Wicomico</b>
Funeral Director	5. Social Security Number <b>215-20-0835</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs	If Under 1 Year Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (MM/DD/YYYY) <b>01/08/1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	10a. State <b>Maryland</b> 10b. County <b>Wicomico</b> 10c. City, Town or Location <b>Pittsville</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>8280 Gumboro Road</b>			10f. Zip Code <b>21850</b>	10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>		College (1-4 or 5+) <b>-</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Domestic</b>	
	17. Father's Name (First, Middle, Last) <b>Alfred Winfred Rohm</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Warren</b>				
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Nancy Jane Hooper/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6314 Friendship Rd., Pittsville, MD 21850</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <b>David J. Thompson CFSP</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pittsville Cemetery</b>	Date <b>9/23/06</b>	20c. Location - City or Town, State <b>Pittsville, MD</b>	
21. Signature of Funeral Service Licensee <b>Holloway Funeral Home Professional Association</b> <b>501 Snow Hill Rd., Salisbury, MD 21804</b>							
22. Name and Address of Facility <b>501 Snow Hill Rd., Salisbury, MD 21804</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) <b>Hypoglycemia with complications due to Administration of Oral Antidiabetic agent</b>							
Approximate Interval Between Death and Disposition							
a. Due to (or as a consequence of): _____							
b. Due to (or as a consequence of): _____							
c. Due to (or as a consequence of): _____							
d. _____							
<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED		item#23a,27,28a-f,perME,g860, 10/6/06 TT			
IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year	
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Dutipatient 3 <input type="checkbox"/> DDA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Fnd 9/9/2006</b>		28b. Time of Injury <b>unknown</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>subject given medication</b>	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Nursing home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>100 E. Carroll Street Salisbury, MD</b>			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>September 21, 2006</b>	
30. Name and address of person who completed cause of death (Item 23a) <b>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>							
31. Date filed (Month, Day, Year) <b>SEP 22 2006</b>		32. Registrar's Signature <b>Thelma H. Powell</b>					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Baltimore, MD 21215-0036  
Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30568  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Betty Lee Ransom</b>							2. Date of Death Month Day Year <b>September 7, 2006</b>	3. Time of Death <b>9:12 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>			4c. County of Death <b>Calvert County</b>	
Funeral Director	5. Social Security Number <b>579-42-3400</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>June 12, 1933</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Calvert County</b>				10c. City, Town or Location <b>Prince Frederick</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>4235 North Shore Drive</b>				10f. Zip Code <b>20678</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1938-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Legal Service</b>				
	17. Father's Name (First, Middle, Last) <b>Harry T. Dixon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth V. Young</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Joy Ann Moran (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8501 Bayside Rd., #607, Chesapeake Beach, MD 20732</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Burial</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Southern Mem. Gardens</b>		Date <b>Sept. 11, 2006</b>	20c. Location - City or Town, State <b>Dunkirk, Maryland</b>			
	21. Signature of Funeral Director Licensee <b>Michael W. Lee</b>				22. Name and Address of Facility <b>Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736</b>				
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metastatic non-small cell carcinoma of lung</b>								Approximate Interval Between Onset and Death <b>Months</b>
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hyper tension</b>								
	b. Due to (or as a consequence of): <b>Coronary artery disease</b>								
	c. Due to (or as a consequence of): <b>Atrial fibrillation</b>								
	d. _____								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hyper tension</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
	<b>Coronary artery disease</b>								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	<b>Atrial fibrillation</b>								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>060390</b>			29d. Date signed (Month, Day, Year) <b>9/7/2006</b>			
	29b. Signature and title of certifier <b>Adeeb Taber, MD</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Adeeb Taber, 100 Hospital Rd., Prince Frederick, MD 20678</b>								
	31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>		32. Registrar's Signature <b>James B. Aponte</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Physician/Medical Examiner

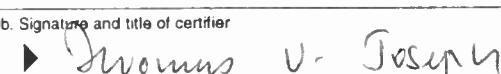
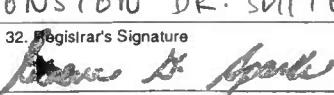
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30569

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Francine Boyd Roberts</b>							2. Date of Death Month 09 Day 11 Year 2006	3. Time of Death 6:05p M
	4a. Facility Name (If not institution, give street and number) <b>Rockville Nursing Home</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>577-64-6976</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>09/07/46</b>	9. Birthplace (State or Foreign Country) <b>Norfolk, Va.</b>		
Usual Residence of Decedent 10a. State Md 10b. County Montgomery 10c. City, Town or Location Rockville 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
10e. Street and Number <b>303 Adclare Road</b>				10f. Zip Code <b>20850</b>			10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Purchasing Agent</b>			16b. Kind of Business/Industry <b>Government</b>				
17. Father's Name (First, Middle, Last) <b>Frank Boyd</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Lee Clair Lane</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Tia D. Roberts Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>611 Shelfar Place Ft. Washington, Md 20744</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverdale Park</b>			Date <b>9/12/06</b>	20c. Location - City or Town, State <b>Riverdale, Md</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Sneath Funeral Home &amp; Cremation Service 5732 Georgia Ave NW Washington, DC 20011</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>MULTIPLE SCLEROSIS</b> <b>PERIPHERAL VASCULAR DISEASE</b> <b>DEMEN TIA</b>							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier 		29c. License number <b>D047330</b>			29d. Date signed (Month, Day, Year) <b>9/12/06</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>50. W. EDMONSTON DR. SUITE 207. ROCKVILLE. MD 20852</b>									
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30570

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death		3. Time of Death	
	Wayne Garfield			Reed, Sr			Month	Day	Year		
Funeral Director	4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death		4c. County of Death	
	The Johns Hopkins Hospital			Baltimore City							
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign Country)			
112-44-9149		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	52 Yrs.	Months	Days	Hours	Min.	Month Day Year	New York		
Usual Residence of Decedent											
10a. State	10b. County	10c. City, Town or Location							10d. Inside City Limits		
MD	Montgomery	Germantown							<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?			
19547 Caravan Drive				20874				U.S.A.			
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: Black		
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry		
Elementary/Secondary (0-12) 12th				College (1-4 or 5+) Bio-medical Engineer					Bayer Diagnostics		
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)							
Leroy H. Reed				Wanda R. Almond							
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Vicky Reed (Wife)				19547 Caraban Drive, Germantown, MD 20874							
20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State		
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				All Souls Cemetery 9/12/06					Germantown, MD		
21. Signature of Funeral Service Licensee											
George R. Reed											
22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St. Rockville, MD 20850											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at 202-562-2000.

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy		23d. Date of delivery			
		<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		Month Day Year			
						<input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)					
23e. Did tobacco use contribute to the cause of death?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Was an autopsy performed?		23g. Were autopsy findings available prior to completion of cause of death?					
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner?		26. Place of Death (Check only one)		27. Manner of Death		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		M		M		<input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one)		29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)					
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		Marisha Cook, MD		RES-000		September 07, 2006					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)		32. Registrar's Signature							
Marisha Cook, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287		SEP 12 2006		Suzanne D. Cook							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

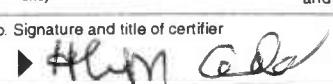
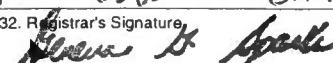
State of Maryland / Department of Health and Mental Hygiene

2006 3057 |

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Cheryl Lambert Roark</b>							2. Date of Death Month Day Year <b>September 10, 2006</b>	3. Time of Death 11:35a M			
	4a. Facility Name (If not institution, give street and number) <b>Gilcrest Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>217-76-5230</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>47</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>November 21, 1958</b>	9. Birthplace (State or Foreign Country) <b>MD</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Cecil</b> 10c. City, Town or Location <b>Port Deposit</b>							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>34 Race St.</b>				10f. Zip Code <b>21904</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4</b>		16b. Kind of Business/Industry <b>Aberdeen Proving Ground</b>							
	17. Father's Name (First, Middle, Last) <b>James B. Lambert</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Francis Hensley</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Robert D. Lambert Sr./Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>34 Race St., Port Deposit, MD 21904</b>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>R.A. Ferris Inc.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>September 11, 2006</b>		Date	20c. Location - City or Town, State <b>West Chester, PA</b>						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Andrew G. Gee Funeral Home</b> <b>259 E. Main St., Elkton, MD 21921</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>Weeks</b>			
	<p>a. <b>Sepsis</b> Due to (or as a consequence of): <b>Wounds</b></p> <p>b. Due to (or as a consequence of): <b>metastatic breast cancer</b></p> <p>c. Due to (or as a consequence of): <b>Chronic pain</b></p> <p>d.</p>								<b>months</b>			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Morbid obesity. HTN, diabetes.</b>  <b>Chronic pain</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice Ctr.</b>		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29b. Signature and title of certifier 		29c. License number <b>00051926</b>		29d. Date signed (Month, Day, Year) <b>Sept. 10, 2006</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen M. Gordon, MD 6565 N. Charles St. Baltimore, MD 21204</b>											
	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30572

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sarah Ford Ripken</b>							2. Date of Death Month Day Year <b>September 13, 2006</b>	3. Time of Death <b>1:45 p M</b>		
	4a. Facility Name (If not institution, give street and number) <b>311 Irish Lane</b>			4b. City, Town, or Location of Death <b>Perryman</b>			4c. County of Death <b>Harford</b>				
Funeral Director	5. Social Security Number <b>213-52-7226</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months <b>86</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>10/04/1919</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Perryman</b>							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>311 Irish Lane</b>			10f. Zip Code <b>21130</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Home</b>				
	17. Father's Name (First, Middle, Last) <b>Harry Grafton Ford, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margreta H. McGuigan</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Joan R. Isom (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8294 Southwind Bay Circle, Fort Myers, FL 33908</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Burial</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sesputia Cemetery</b>		Date <b>09/16/2006</b>	20c. Location - City or Town, State <b>Perryman, Maryland</b>				
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <b>Jane Bellman</b>			22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. 333 South Parke St., Aberdeen, MD 21001</b>							
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sepsis &amp; CHF endstage cardiovascular disease</b>							Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>atherosclerotic vascular disease</b>										
	a. Due to (or as a consequence of): <b>Sepsis &amp; CHF endstage cardiovascular disease</b>		b. Due to (or as a consequence of): <b>Cardiovascular disease</b>		c. Due to (or as a consequence of): <b>atherosclerotic vascular disease</b>						
	d.										
	IF FEMALE: <b>N/A</b>		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year <b>N/A</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							28a. Date of Injury (Month, Day Year) <b>8/14/06</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29c. License number <b>00023981</b>		29d. Date signed (Month, Day, Year) <b>9/14/06</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph P. Grant, M.D. 560 W. MacPhail Rd, Bel Air, MD 21014</b>							32. Registrar's Signature <b>John A. Bellman</b>			
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>							33. Date signed (Month, Day, Year)			

Baltimore, Maryland 21215-0036

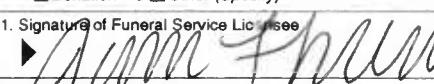
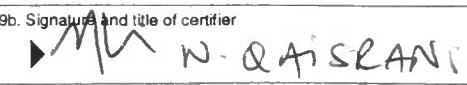
Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
1- For Amend item#PI 23a-d, 27,28a-f,perME,gs59,9/26/06 TT // Amend Item#31,perDVR  
State Registrar Certificate of Death Reg. No.

2006 30573

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Gertrude Smith</b>							2. Date of Death Month Day Year <b>September 18, 2006</b>	3. Time of Death <b>10:40 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Cumberland</b>			4c. County of Death <b>Allegany</b>			
Funeral Director	5. Social Security Number <b>215-20-7462</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jul 26, 1914</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Allegany</b> 10c. City, Town or Location <b>Cumberland</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number <b>715 Edgevale Avenue</b>					10f. Zip Code <b>21502</b>	10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>X</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify:		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Superintendent</b>			16b. Kind of Business/Industry <b>nursery</b>				
17. Father's Name (First, Middle, Last) <b>Henry Lee Twigg</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Loretta Morrison Twigg</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Scott Smith</b> grandson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10528 Mt. Savage Road Cumberland MD 21502</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hillcrest Memorial Park</b>			Date <b>9/21/2006</b>	20c. Location - City or Town, State <b>Cumberland MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Scarpelli Funeral Home, PA</b> <b>108 Virginia Avenue: Cumberland, MD 21502</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hop Fracture</b>										
Immediate Cause (Final disease or condition resulting in death) <b>Cardiac Arrhythmia</b>										
Approximate Interval Between Onset and Death										
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (Specify)										
23d. Date of delivery Month Day Year <b>Sept 20 2006</b>										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day Year) <b>9/10/2006</b>		28b. Time of Injury <b>6:45 p M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>patient fell</b>				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>New Hope Assisted Living</b>										
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Mexico Farms Cumberland</b>										
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  <b>N. Qaisrani</b>					29c. License number <b>D 64167</b>			29d. Date signed (Month, Day, Year) <b>September 19, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. Qaisrani 47 VIRGINIA AVE. CUMBERLAND MD 21502</b>										
31. Date filed (Month, Day, Year) <b>SEP 26 2006</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be certified at once.

2728a-f

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death2006 30574  
Reg. No.1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alvena Hey Stewart</b>						2. Date of Death Month Day Year <b>September 7, 2006</b>	3. Time of Death <b>9:10 P M</b>
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Prince Frederick</b>			4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>229-05-2833</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months <b>87</b>	If Under 24 Hrs. Hours <b>0</b>	8. Date of Birth (Month, Day, Year) <b>June 28, 1919</b>	9. Birthplace (State or Foreign Country) <b>South Carolina</b>	
	Usual Residence of Decedent 10a. State <b>MD</b>			10b. County <b>Anne Arundel</b>			10c. City, Town or Location <b>Deale</b>	
10e. Street and Number <b>5916 # A Deale Churchton Road</b>				10f. Zip Code <b>20751</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1940-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>1</b>		16b. Kind of Business/Industry <b>real estate agent</b>			16c. Kind of Business/Industry <b>real estate</b>	
17. Father's Name (First, Middle, Last) <b>Henry Thomas Hey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eula Mae Stuckey</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Michael S. Stewart, son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5916 # A Deale Churchton Rd. Deale, MD 20751</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Metropolitan Crematory</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>09-09-06 Alexandria, VA</b>				
21. Signature of Funeral Service Licensee <b>William R. Gwin</b>				22. Name and Address of Facility <b>Rausch Funeral Home, P.A., Owings, MD 20736</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Intra cerebral Haemorrhage</b>				Approximate Interval Between Onset and Death				
b. <b>Rupture Aneurysm</b> Due to (or as a consequence of):								
c. <b>Atherosclerotic Cardiovascular disease</b> Due to (or as a consequence of):								
d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b> <b>Bronchiectasis</b> <b>Congestive Heart Failure</b>								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D 50653</b>		29d. Date signed (Month, Day, Year) <b>9-8-2006</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GYAN - C. SURANA</b> <b>5851 - Deale Churchton Road - Deale MD 20751</b>								
31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>		32. Registrar's Signature <b>James B. Aponte</b>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

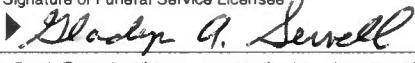
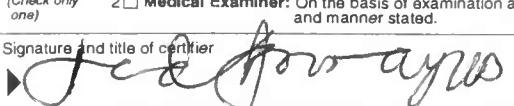
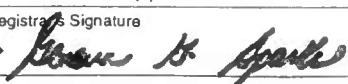
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30575

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Russell Rudolph Smith, Jr.</b>							2. Date of Death Month Day Year <b>Sep 4, 2006</b>	3. Time of Death M <b>08:35 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital</b>			4b. City, Town, or Location of Death <b>Cheverly</b>			4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>219-48-6758</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Feb 5, 1948</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>MD</b>			10b. County <b>Calvert</b>			10c. City, Town or Location <b>Prince Frederick</b>		
10e. Street and Number <b>175 Mason Road</b>				10f. Zip Code <b>20678</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1966 1970</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-Employed Salvage Worker</b>			16b. Kind of Business/Industry <b>Salvaging</b>		
17. Father's Name (First, Middle, Last) <b>Russell Rudolph Smith, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Ida Parran</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carol Stewart/sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 189 Prince Frederick, MD 20678</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cheltenham Veterans Cemetery</b>			Date <b>09/12/06</b>	20c. Location - City or Town, State <b>Cheltenham, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>FATAL CARDIAC ARRHYTHMIA</b> Due to (or as a consequence of): <b>BITEMPORAL STROKES</b> Due to (or as a consequence of): <b>CHRONIC ATRIAL FIBRILLATION</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>Minutes 50 Days 3 yrs</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D28195</b>						29d. Date signed (Month, Day, Year) <b>9-5-06</b>	
29b. Signature and title of certifier 									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR DAVID GOORAY 3001 HOSPITAL DR CHEVERLY, MD 20785</b>									
31. Date filed (Month, Day, Year) <b>SEP 6 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner shall be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30576

## Certificate of Death

Reg. No. \*

For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donna Leigh Seeders

2. Date of Death

Month Day Year  
September 9, 2006

3. Time of Death

1:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4377 Maryland Highway

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

217-54-6838

6. Sex

 M F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 26 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent  
10a. State MD Garrett  
10b. County Oakland  
10e. Street and Number 4377 Maryland Highway  
10f. Zip Code 21550  
10g. Citizen of What Country? United States

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

11. Marital Status

 Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 Yes  No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12) 12  
College (1-4 or 5+) Owner & Operator16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Owner &amp; Operator

16b. Kind of Business/Industry

Framing Shop

17. Father's Name (First, Middle, Last)

Elmer Crone

18. Mother's Name (First, Middle, Maiden Surname)

Helen Tatterson

19a. Informant's Name/Relationship (Type, Print)

Mr. Jimmie L. Seeders

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4377 Maryland Highway, Oakland, MD 21550

20a. Method of Disposition

 Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

Date

20c. Location - City or Town, State

9/12/06

Cumberland, MD

21. Signature of Funeral Service Licensee

Katherine Seeger

22. Name and Address of Facility

Burdock-Durst Funeral Home  
21 N. Second St., Oakland, MD 21550

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

23b. Approximate Interval Between Onset and Death

minutes

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown23c. If yes, outcome of pregnancy  
 Live birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death?

 Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

 Yes  No

26. Place of Death (Check only one)

Hospital:  Inpatient  ER/Outpatient  DOA Other:  Nursing Home  Residence  Other (Specify)

27. Manner of Death

 Natural  Pending investigation  
 Accident  Could not be determined  
 Suicide  Determined  
 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

M

1  Yes  No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DR. Robert Goralski

29c. License number

D23979

29d. Date signed (Month, Day, Year)

9.9.6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Robert Goralski, 311 N. Fourth St., Oakland, Md 21550

31. Date filed (Month, Day, Year)

SEP 11 2006

32. Registrar's Signature

Kathleen A. Smith

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg No.

2006 30577

**1- For State Registrar**

1. Decedent's Name (First, Middle, Last)

**SAMANTHA MICHELE SNIDER**

2 Date of Death

Month

Day

Year

September 8, 2006

3 Time of Death

1939 hrs

**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director**

4a. Facility Name (if not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>				4c. County of Death <b>Washington</b>	
5 Social Security Number <b>217-19-2393</b>	6 Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>19 Yrs.</b>	If Under 1 Year Months <b> </b>	If Under 24 Hrs Days <b> </b>	8. Date of Birth (MM/DD/YYYY) <b>Aug. 28, 1987</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent <b>Maryland Washington</b>		10c. City, Town or Location <b>Hagerstown</b>						10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	
10e. Street and Number <b>13628 Royal Road</b>				10f. Zip Code <b>21742</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
11 Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> specify: <b>White</b>			14. Race - American Indian, Black, White, etc.		
15 Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) <b>College (1-4 or 5+) Waitress</b>		16b. Kind of Business/Industry <b>Restaurant</b>					
17. Father's Name (First, Middle, Last) <b>Steven Donald Snider</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lisa Valek</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Steven D. Snider / Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19706 Crystal Rock Dr., Germantown, MD 20874</b>					
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>			Date <b>9/13/06</b>	20c. Location - City or Town, State <b>Frederick, Maryland</b>			
21. Signature of Funeral Service Licensee <b>R. Titus D.E.</b>				22. Name and Address of Facility <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701</b>					

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a Hanging</b> Due to (or as a consequence of):  <b>b</b> Due to (or as a consequence of):  <b>c</b> Due to (or as a consequence of):  <b>d</b>  <b>UNPENDED</b> <b>AMENDED</b>				Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I				23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>			
25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		26 Place of Death (Check only one) Hospital <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other</b>					
27. Manner of Death <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Suicide</b>		28a. Date of Injury (Month, Day, Year) <b>FOUND: Sep 8, 2006</b>	28b. Time of Injury <b>FOUND: 1904 hrs</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	28d. Describe how injury occurred <b>Subject hanged self</b>		
29a. Certifier (Check only one) <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Single Family</b>					
29b. Signature and title of certifier <b>J. Titus, M.D.</b>		29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>September 9, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) <b>Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>							
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature <b>James A. Smith</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

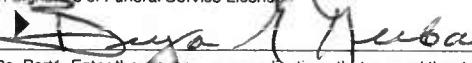
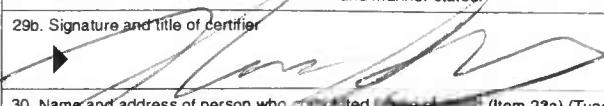
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30578

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Hartwell Tucker</b>						2. Date of Death Month Day Year <b>September 11 2006</b>	3. Time of Death 10:45 A M
	4a. Facility Name (If not institution, give street and number) <b>Heart Homes</b>			4b. City, Town, or Location of Death <b>Linthicum</b>			4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>579-10-1877</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>90 Yrs.</b>		If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 23, 1915</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>
	Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Lusby</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>1226 White Sands Drive</b>			10f. Zip Code <b>20657</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>4</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify:
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>4</b> <b>service manager</b>		16b. Kind of Business/Industry <b>auto dealer</b>				
17. Father's Name (First, Middle, Last) <b>Hartwell Tucker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Adeline Reteneller</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Geraldine Wassmann, daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>503 LaClair Ave., Linthicum Heights, MD 21090</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>			Date <b>09-15-2006</b>	20c. Location - City or Town, State <b>Suitland, MD</b>	
21. Signature of Funeral Service License 								
22. Name and Address of Facility Rausch Funeral Home, P.A. <b>8325 Mt. Harmony Lane, Owings, MD 20736</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (First disease or condition resulting in death) <b>Cerebrovascular Disease</b>								
Approximate Interval Between Onset and Death <b>44-5</b>								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<p>a. Due to (or as a consequence of): <b>Cerebrovascular Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) <b>Hartwell</b>								
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 								
29c. License Number <b>031551</b>								
29d. Date signed (Month, Day, Year) <b>September 12, 2006</b>								
30. Name and address of person who filed (Item 23a) (Type, Print) <b>Russell O. Lewis 305 Hospital Drive, Glen Burnie, Md. 21061</b>								
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>								
32. Registrar Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

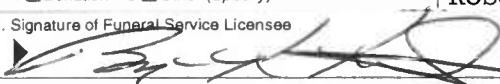
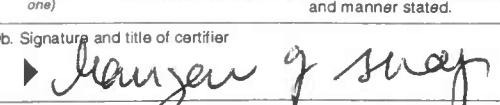
Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #23a State of Maryland / Department of Health and Mental Hygiene  
1- For State Registrar WCHD/SH 9/13/06 per Dr Certificate of Death

2006 30579  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sarah Elizabeth Trammell</b>							2. Date of Death Month September Day 10 Year 2006	3. Time of Death 8:00pm M
	4a. Facility Name (If not institution, give street and number) <b>Ravenwood Lutheran Village</b>			4b. City, Town, or Location of Death <b>Hagerstown</b>			4c. County of Death <b>Washington</b>		
Funeral Director	5. Social Security Number <b>214-09-2467</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>11/30/1916</b>	9. Birthplace (State or Foreign Country) <b>WV</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Washington</b> 10c. City, Town or Location <b>Hagerstown</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>10902 Allen Avenue</b>			10f. Zip Code <b>21740</b>			10g. Citizen of What Country? <b>US</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Manager</b>			16b. Kind of Business/Industry <b>Furniture</b>			
	17. Father's Name (First, Middle, Last) <b>William Ernest Trammell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lou Belle Kibler</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Connie Brinton (Niece)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>507 9th Street, New Cumberland, PA 17070</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Rosedale Cemetery</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rosedale Cemetery</b>			Date <b>09/13/2006</b>	20c. Location - City or Town, State <b>Martinsburg, WV</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Chronic kidney disease</b> Approximate Interval Between Onset and Death <b>5 years</b>								
	a. Due to (or as a consequence of): <b>Chronic renal failure</b> b. Due to (or as a consequence of): <b>Failure to thrive</b> c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9</b> <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> M <input type="checkbox"/> Yes <input type="checkbox"/> No								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>								
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Hagerstown, MD 21740</b>								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								
	29c. License number <b>D28365</b>								
	29d. Date signed (Month, Day, Year) <b>9-11-06</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYANNE D. SPERL 368 Main Street Hagerstown MD 21740</b>								
	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>			32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30580  
Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Toliaferro</b>							2. Date of Death Month 08	Day 31	Year 2006	3. Time of Death 7:20 A M
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>579-22-9553</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81 Yrs.</b>		If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>3-2-1925</b>	9. Birthplace (State or Foreign Country) <b>Amherst, VA</b>		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Silver Spring</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
To Be Completed by Funeral Director	10e. Street and Number <b>1009 Rosemere Avenue</b>				10f. Zip Code <b>20904</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc.			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Courier</b>			16b. Kind of Business/Industry <b>Self Employed</b>			
	17. Father's Name (First, Middle, Last) <b>Unknown</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Andrea Toliaferro/Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1009 Rosemere Ave, Silver Spring, MD 20904</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cheltenham Veterans</b>			Date <b>09-11-06</b>	20c. Location - City or Town, State <b>Cheltenham, MD</b>				
	21. Signature of Funeral Service Licensee <b>Julia P. Marshall</b>					22. Name and Address of Facility <b>Marshall's Funeral Home 4217 9th St NW, Wash., DC 20011</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cardio-pulmonary failure</b> Due to (or as a consequence of):  Sequelae (if any, leading to immediate cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Necrotizing Bronchopneumonia</b> Due to (or as a consequence of):  <b>Hypertensive Atherosclerotic Heart Disease</b> Due to (or as a consequence of):  d.									Approximate Interval Between Onset and Death	
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D64024</b>			29d. Date signed (Month, Day, Year) <b>08-31-2006</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Janna Lachtchinina 1500 Forest Glen Road, Silver Spring, MD 20910</b>										
	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature <b>Janna Lachtchinina</b>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

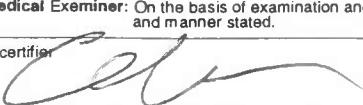
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30581

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLOTTE K THOMPSON</b>							2. Date of Death Month Day Year <b>September 9, 2006</b>	3. Time of Death <b>6:40 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>FREDERICK</b>			4c. County of Death <b>FREDERICK</b>			
Funeral Director	5. Social Security Number <b>578-30-4103</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 1, 1924</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Frederick</b> 10c. City, Town or Location <b>Thurmont</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	10e. Street and Number <b>13 North Altamont Avenue</b>			10f. Zip Code <b>21788</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Charles William Harmon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie McAfee</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Raymond Thompson / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>200 Emmitsburg Road, Thurmont, MD 21788</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Carmel Cemetery</b>			Date <b>9/12/06</b>	20c. Location - City or Town, State <b>Thurmont, Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.</b> <b>615 EAST MAIN ST., THURMONT, MD 21788</b>					
Physician /Medical Examiner	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>2 mo</b>		
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>HTN</i> <i>A fibillation</i> <i>liver metastasis</i>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 			
	29c. License number <b>D17549</b>						29d. Date signed (Month, Day, Year) <b>9/1/06</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Harper, MD 100 South Center Street, Thurmont, MD 21788</b>									
	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30582

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Allen L. Trickett</b>							2. Date of Death Month Day Year <b>September 9, 2006</b>	3. Time of Death 10:10A M
	4a. Facility Name (If not institution, give street and number) <b>Genesis Eldercare</b>			4b. City, Town, or Location of Death <b>La Plata</b>			4c. County of Death <b>Charles</b>		
Funeral Director	5. Social Security Number <b>579-46-0015</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	8. Date of Birth (Month Day Year) <b>May 27, 1937</b>	9. Birthplace (State or Foreign Country) <b>WashingtonDC</b>	
	10a. State <b>MD</b>		10b. County <b>Charles</b>	10c. City, Town or Location <b>La Plata</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>One Magnolia Drive</b>				10f. Zip Code <b>20646</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookeeper</b>		16b. Kind of Business/Industry <b>Accounting</b>				
	17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Cathy Tarbarton/Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Magnolia Drive, La Plata, MD 20646</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Brinsfield-Echols 9/12/06</b>				Date <b>Charlotte Hall, MD</b>	20c. Location - City or Town, State <b>20646</b>			
	21. Signature of Funeral Service Licensee <b>Daniel C. Echols</b>				22. Name and Address of Facility <b>Arehart-Echols Funeral Home 211 St. Mary's Ave. La Plata, MD 20646</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Terminal Aspiration</b>				Approximate Interval Between Onset and Death				
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>								
	23c. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <b>Fatima Hussein, M.D.</b>				29c. License number <b>055455</b>		29d. Date signed Month, Day, Year <b>9/11/06</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Fatima Hussein, M.D. 5625 Allentown Rd. Suite 101, Camp Springs, MD</b>				31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>				
					32. Registrar's Signature <b>Debra B. Spangler</b>				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

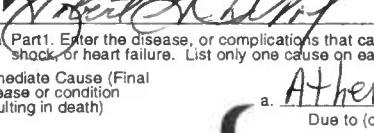
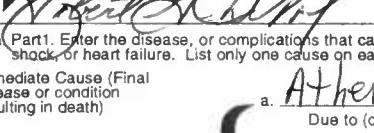
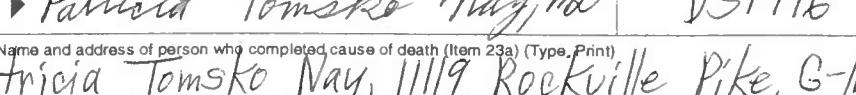
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

## *Certificate of Death*

Reg. No.

2006 30583

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>LAWRENCE ALLAN VANCE</b>						2. Date of Death Month Day Year <b>September 9, 2006</b>		3. Time of Death <b>10:50 AM</b>	
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>202 Park Avenue #409</b>			4b. City, Town, or Location of Death <b>Gaithersburg</b>			4c. County of Death <b>Maryland</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>401-64-5359</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>June 19, 1949</b>	9. Birthplace (State or Foreign Country) <b>Kentucky</b>		
		Usual Residence of Decedent		10a. State <b>Md.</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
		10e. Street and Number <b>202 Park Avenue #409</b>						10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>United States</b>	
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
		15. Decedent's Education (Specify only highest grade completed)  <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <b>College (1-4 or 5+)</b> <b>5+</b>			16b. Kind of Business/Industry  <b>Computer Systems Analyst</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lela Mae Friend</b>	
		17. Father's Name (First, Middle, Last) <b>Lawrence L. Vance</b>									
		19a. Informant's Name/Relationship (Type, Print) <b>Lawrence L. Vance (Father)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3740 Scottsville Road Glasgow, Kentucky 42141</b>							
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Walnut Hill Cemetery</b>		Date <b>Sept. 14, 2006</b>		20c. Location - City or Town, State <b>Glasgow, Kentucky</b>			
21. Signature of Funeral Service Licensee  		22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 East Deer Park Dr. Gaithersburg, Md. 20877</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of):  <b>Atherosclerotic cardiovascular disease</b>								Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):  _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29d. Date signed (Month, Day, Year) <b>Sept. 9, 2006</b>	
29b. Signature and title of certifier  		29c. License number <b>D51916</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  <b>Patricia Tomsko Nay, 11119 Rockville Pike, G-100, Rockville, MD 20852</b>		32. Registrar's Signature  								31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>	

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

## **Medical Certification: To Be Completed by Physician/Medical Examiner**

Baltimore, Maryland 21215-0036

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, **the Medical Examiner must be notified at once.**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2006 30584

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roy Anton Vogt</b>							2. Date of Death Month Day Year <b>September 10 2006</b>	3. Time of Death <b>4:30 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>			4b. City, Town, or Location of Death <b>Bethesda</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>442-10-1846</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>May 31, 1915</b>	9. Birthplace (State or Foreign Country) <b>Kansas</b>	
	Usual Residence of Decedent								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Ijamsville</b>						10g. Citizen of What Country? <b>U.S.A.</b>	
	10e. Street and Number <b>11108 Mountain View Lane</b>			10f. Zip Code <b>21754</b>			10h. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11108 Mountain View Lane, Ijamsville, Maryland 21754</b>			
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>8</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Master Plumber</b>			16b. Kind of Business/Industry <b>Plumbing</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Paul Robert Vogt</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Willie Ann Snead</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Jack L. Vogt - Son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11108 Mountain View Lane, Ijamsville, Maryland 21754</b>				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>D</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bethesda Methodist</b>			Date <b>Sept. 15, 2006</b>	20c. Location - City or Town, State <b>Damascus, Maryland 20872</b>		
	21. Signature of Funeral Service Licensee <b>Robert L. Williams</b>					22. Name and Address of Facility <b>Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):										
23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown										
23d. Date of delivery Month Day Year										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day Year) <b>September 10, 2006</b> 28b. Time of Injury <b>M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Rajan Smyamsundar M.D.</b>										
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3411 Olandwood Court - Suite 105, Olney, Maryland 20832</b>										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Rajan Smyamsundar M.D.</b>										
29c. License number <b>D53367</b>										
29d. Date signed (Month, Day, Year) <b>September 10, 2006</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rajan Smyamsundar M.D. 3411 Olandwood Court - Suite 105, Olney, Maryland 20832</b>										
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>										
32. Registrar's Signature <b>Heather G. Smith</b>										

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 301-455-5454.

VOGT, ROY September 10, 2006 0430 AM

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached (or use as the burial-transit slip).

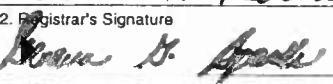
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30585

1- For State Registrar		2. Date of Death Month Day Year										3. Time of Death			
Physician /Medical Examiner		Decedent's Name (First, Middle, Last) <b>Dolores Mildred VanSant</b>					4a. Facility Name (If not institution, give street and number) <b>COASTAL HOSPICE AT THE LAKE</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>			4c. County of Death <b>WICOMICO</b>			
Funeral Director		5. Social Security Number <b>220-22-4800</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b>	Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>9/27/1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
To Be Completed by Funeral Director		Usual Residence of Decedent													
		10a. State <b>Maryland</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Salisbury</b>									10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number <b>2538 Old Ocean City Rd.</b>				10f. Zip Code <b>21804</b>				10g. Citizen of What Country? <b>USA</b>					
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify:				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>-</b> Waitress			16b. Kind of Business/Industry <b>Food Service</b>							
		17. Father's Name (First, Middle, Last) <b>John Robert Bruce</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Heath</b>									
		19a. Informant's Name/Relationship (Type, Print) <b>Linda L. Miller/daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2538 Old Ocean City Rd., Salisbury, MD 21804</b>											
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens</b>			Date <b>9/13/06</b>			20c. Location - City or Town, State <b>Hebron, MD</b>				
		21. Signature of Funeral Service Licensee <b>Ronald A. Thompson CFSP</b>													
		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>													
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
		<p>a. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of):</p> <p>b. <b>CARCINOID TUMOR OF LUNGS</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>													
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred							
				<b>M</b>											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
		29b. Signature and title of certifier 		29c. License number <b>00058410</b>				29d. Date signed (Month, Day, Year) <b>9/9/06</b>							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHARLES WARIS 26266 ARROWWOOD CT. SALISBURY MD. 21801</b>													
		31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>		32. Registrar's Signature 											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

bally

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30586

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Watts</b>							2. Date of Death Month Day Year <b>Sep 7, 2006</b>	3. Time of Death M <b>3:30 P M</b>
	4a. Facility Name (If not institution, give street and number) <b>Solomons Nursing Center</b>			4b. City, Town, or Location of Death <b>Solomons</b>			4c. County of Death <b>Calvert</b>		
Funeral Director	5. Social Security Number <b>220-09-2467</b>		6. Sex <b>1 X M 2 □ F</b>	7. Age (In yrs. last birthday) <b>92 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Jan 3, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent		10a. State <b>MD</b>			10b. County <b>Calvert</b>			10c. City, Town or Location <b>Lusby</b>
To Be Completed by Funeral Director	10e. Street and Number <b>11790 Mill Bridge Road</b>				10f. Zip Code <b>20657</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <b>1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 X No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 X No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Truck Driver</b>			16b. Kind of Business/Industry <b>Lumber</b>		
17. Father's Name (First, Middle, Last) <b>John Watts</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Hutchins</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Eliza Foote/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 118 Lusby, MD 20657</b>					
20a. Method of Disposition <b>1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Gethsemane Holiness Church</b>			Date <b>09/12/06</b>	20c. Location - City or Town, State <b>Huntingtown, MD</b>	
21. Signature of Funeral Service Licensee <b>Glady A. Sewell</b>				22. Name and Address of Facility <b>Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Gastrinoma of Prostate</b> Approximate Interval Between Onset and Death <b>4 years</b>								
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): <b>Gastrinoma</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____								
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 □ No 9 □ Unknown</b>		23c. If yes, outcome of pregnancy <b>1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown</b>					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe Demencia</b>									
23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 □ No 3 □ Probably 4 X Unknown</b>									
25. Was case referred to medical examiner? <b>1 □ Yes 2 X No</b>		26. Place of Death (Check only one) Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)</b>							
27. Manner of Death <b>1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide</b>		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>		28c. Injury at Work? <b>1 □ Yes 2 □ No</b>		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>									
29b. Signature and title of certifier <b>AT munsif M.D. Attending Physician</b>		29c. License number <b>D 19427</b>			29d. Date signed (Month, Day, Year) <b>9 8 06</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANWAR MUNSHI M.D. 110 HOSPITAL RD. PRINCE FREDERICK MD 20678</b>									
31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>		32. Registrar's Signature <b>James B. Jones</b>							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30587  
Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

WILLIAMS, Eva I  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Eva Irene Williams</b>		2. Date of Death Month Day Year <b>SEPTEMBER 14, 2006</b>		3. Time of Death <b>7:25 A M</b>
4a. Facility Name (if not institution, give street and number) <b>RAVENWOOD LUTHERAN VILLAGE</b>		4b. City, Town, or Location of Death <b>HAGERSTOWN</b>		4c. County of Death <b>WASHINGTON</b>
5. Social Security Number <b>215-18-1398</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93 Yrs.</b>	If Under 1 Year Months Days Hours Min. Oct 2 1912
8. Date of Birth (Month, Day, Year) <b>Oct 2 1912</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
10a. State <b>Maryland</b>		10b. County <b>Washington</b>	10c. City, Town or Location <b>Hagerstown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>1182 Luther Drive</b>		10f. Zip Code <b>21740</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>8</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Inspector</b>		16b. Kind of Business/Industry <b>Garment Mfg.</b>
17. Father's Name (First, Middle, Last) <b>Charles W. Taylor</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Speaker</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Kenneth Leon Williams (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21916 Holiday Drive Smithsburg Maryland 21783</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Boonsboro Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bakersville Cemetery</b> Date <b>9-18-2006</b> 20c. Location - City or Town, State <b>Boonsboro Maryland</b>		
21. Signature of Funeral Service Licensee <b>Charles W. Taylor</b>		22. Name and Address of Facility Douglas A. Fiery Funeral Home <b>1331 Eastern Blvd. N. Hagerstown Maryland 21742</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CONGESTIVE HEART FAILURE</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>A CUTE RENAL FAILURE</b>				
Approximate Interval Between Onset and Death				
a. Due to (or as a consequence of): <b>CONGESTIVE HEART FAILURE</b>				
b. Due to (or as a consequence of): <b>A CUTE RENAL FAILURE</b>				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>AORTIC STENOSIS, CORONARY ARTERY DISEASE, ANASARCA, BIBASCULAR PNEUMONIA</b>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>SEP 15 2006</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>368 MILL STREET, HAGERSTOWN, MD 21740</b>		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier <b>MD</b>		29c. License number <b>DD062327</b>		29d. Date signed (Month, Day, Year) <b>9/14/06</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>368 MILL STREET, HAGERSTOWN, MD 21740</b>				
31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>		32. Registrar's Signature <b>Susan G. Sparks</b>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30588  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Windsor</b>				2. Date of Death Month Day Year <b>Sept. 9, 2006</b>	3. Time of Death <b>10:48 AM</b>									
	4a. Facility Name (If not institution, give street and number) <b>7641 Green Lewis Road</b>		4b. City, Town, or Location of Death <b>Willards</b>		4c. County of Death <b>Wicomico</b>										
Funeral Director	5. Social Security Number <b>214-10-6474</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89 Yrs.</b>	If Under 1 Year Months Days Hours Min. <b>0 0 0 0</b>	8. Date of Birth (Month, Day, Year) <b>April 2, 1917</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>									
	Usual Residence of Decedent  10a. State <b>MD</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Willards</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Funeral Director	10e. Street and Number <b>7641 Green Lewis Road</b>			10f. Zip Code <b>21874</b>		10g. Citizen of What Country? <b>USA</b>									
	11. Marital Status  <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1940</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>									
	15. Decedent's Education (Specify only highest grade completed)  <b>Elementary/Secondary (0-12) 6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <b>Homemaker</b>			16b. Kind of Business/Industry  <b>Own Home</b>									
	17. Father's Name (First, Middle, Last) <b>William Asbury</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ennis Dora Mae</b>			unknown								
	19a. Informant's Name/Relationship (Type, Print) <b>Debbie Windsor-daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  <b>7641 Green Lewis Road Willards, MD 21874</b>		Date <b>9/12/2006</b>	20c. Location - City or Town, State <b>Salisbury, Maryland</b>									
	20a. Method of Disposition  <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Parsons Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)												
	21. Signature of Funeral Service Licensee  <b>Mrs. Harry Blake</b>		22. Name and Address of Facility  <b>Bounds Funeral Home 705 E Main Street Salisbury, MD 21804</b>												
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  <b>ASLV1</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  <b>COPD</b>														
	Approximate Interval Between Onset and Death														
	<table border="0"> <tr> <td>a.</td> <td>Due to (or as a consequence of):  <b>ASLV1</b></td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):  <b>COPD</b></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>							a.	Due to (or as a consequence of):  <b>ASLV1</b>	b.	Due to (or as a consequence of):  <b>COPD</b>	c.	Due to (or as a consequence of):	d.	
a.	Due to (or as a consequence of):  <b>ASLV1</b>														
b.	Due to (or as a consequence of):  <b>COPD</b>														
c.	Due to (or as a consequence of):														
d.															
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy  <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
	23e. Did tobacco use contribute to the cause of death?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown														
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No												
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
	26. Place of Death (Check only one)  Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
	27. Manner of Death  <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred									
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)														
	28f. Location (Street and Number or Rural Route Number, City or Town, State)														
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
	29b. Signature and title of certifier  <b>Natalie Nilesen</b>		29c. License number <b>347044</b>			29d. Date signed (Month, Day, Year) <b>9/11/06</b>									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  <b>Natalie Nilesen 1415 S. DIVISION STREET SALISBURY MD 21804</b>														
	31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>		32. Registrar's Signature  <b>Natalie Nilesen</b>												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30589

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH E. YOUNG</b>						2. Date of Death Month Day Year <b>09-03-2006</b>	3. Time of Death 3: 30 P M
	4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>			4b. City, Town, or Location of Death <b>CLINTON</b>			4c. County of Death <b>PRINCE GEORGE'S</b>	
Funeral Director	5. Social Security Number <b>579-54-0190</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>06-06-1941</b>	9. Birthplace (State or Foreign Country) <b>Orange, N.J.</b>	
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Temple Hills</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>2813 Colebrook Drive</b>			10f. Zip Code <b>20748</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>			16b. Kind of Business/Industry <b>Private Industry</b>	
	17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Vernitta Young-Lee/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2813 Colebrook Drive Temple Hills, Maryland 20748</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Mary E. Hedgeman 1374</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverdale Park Crem.</b>		Date <b>09-18-06</b>	20c. Location - City or Town, State <b>Suitland, Maryland</b>		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <b>Mary E. Hedgeman 1374</b>				22. Name and Address of Facility <b>Cedar Hill FH 4111 Pennsylvania Ave. Suitland, Maryland</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death months			
	a. <b>Cancer of Pancreas</b> Due to (or as a consequence of):							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcohol Abuse</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	<b>Gastric Outlet Obstruction</b>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Hilary Washington</b>			
					29c. License number <b>D32800</b>			29d. Date signed (Month, Day, Year) <b>Sept. 12, 2006</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Hilary Washington, MD 11701 Livingston Rd. #205 Ft. Washington, Maryland 20744</b>				31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>			
					32. Registrar's Signature <b>Heaven A. Apollon</b>			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, a Medical Examiner must be notified at once.

CR

State  
Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2006 30590

### *Certificate of Death*

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID WILLIAM ZINN</b>						2. Date of Death Month <b>8</b> Day <b>31</b> Year <b>06</b> 0503 AM	3. Time of Death	
	4a. Facility Name (If not institution, give street and number) <b>Garrett County Memorial Hosp</b>			4b. City, Town, or Location of Death <b>OAKLAND</b>			4c. County of Death <b>Garrett</b>		
Funeral Director	5. Social Security Number <b>224-72-3337</b>	6. Sex <b>XXM</b> 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>55</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>8/12/1951</b>	9. Birthplace (State or Foreign Country) <b>Morgantown, WV</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>WV</b> 10b. County <b>Preston</b> 10c. City, Town or Location <b>Terra Alta</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>RR 1 Box 59A</b>			10f. Zip Code <b>26764</b>			10g. Citizen of What Country? <b>U.S.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1960-1964</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) U.S. Army</b>			16b. Kind of Business/Industry <b>Veteran</b>		
	17. Father's Name (First, Middle, Last) <b>William Thomas Zinn</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Carlin Kay Hall Zinn</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Buseman</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>200 Jackson Street Apt. 2, Kingwood, WV 26537</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>WV National Cemetery</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WV National Cemetery</b>			Date <b>9/5/2006</b>	20c. Location - City or Town, State <b>Grafton, WV</b>	
	21. Signature of Funeral Service Licensee <b>Mark C. Spear</b>			22. Name and Address of Facility <b>Arthur H. Wright Funeral Home 105 Highland Avenue, Terra Alta, WV 26764</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Arteriosclerotic coronary artery disease</b>						Approximate Interval Between Onset and Death <b>years</b>		
	{ b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Due to (or as a consequence of):								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <b>Paul Daniel Miller</b>			29c. License number <b>1T26154</b>			29d. Date signed (Month, Day, Year) <b>9/1/06</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Daniel Miller DOB 69WA (FACES OAKLAND WV)</b>								
	31. Date filed (Month, Day, Year) <b>SEP - 8 2006</b>			32. Registrar's Signature <b>[Signature]</b>					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 26a-1 show any injury or other traumatic event, the Medical Examiner must be notified.

To Be Completed by Funeral Director

**1 - For  
State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30591

Reg. No.

1-  
For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Francis Robert Ziegelheaver</b>					2. Date of Death Month Day Year <b>September 11, 2006</b>	3. Time of Death <b>7:15 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>1209 Walnut Street</b>			4b. City, Town, or Location of Death <b>Delmar</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>214-14-4416</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <b>May 15, 1921</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent 10a. State <b>MD</b>			10b. County <b>Wicomico</b>			10c. City, Town or Location <b>Delmar</b>
To Be Completed by Funeral Director	10e. Street and Number <b>1209 Walnut Street</b>			10f. Zip Code <b>21875</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-1945</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white		14. Race - American Indian, Black, White, etc. Specify: white
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrical Foreman</b>			16b. Kind of Business/Industry <b>Steel Company</b>
	17. Father's Name (First, Middle, Last) <b>Peter J. Ziegelheaver</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Ruth</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Katherine Ziegelheaver (wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1209 Walnut Street Delmar, MD 21875</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Gardens of Faith</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		Date <b>09-15-2006</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>
21. Signature of Funeral Service Licensee <b>Amy Short-Jewell</b>			22. Name and Address of Facility <b>Short Funeral Home</b>			13 E. Grove Street Delmar, DE 19940	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): <b>Emphysema</b>			Approximate Interval Between Onset and Death <b>20 years</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Due to (or as a consequence of): <b>Bladder Cancer</b>			Approximate Interval Between Onset and Death <b>1 year</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>40050743</b>			29d. Date signed (Month, Day, Year) <b>8/12/2006</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Brandon, D.O. 1205 Pemberton Dr. Salisbury MD</b>			32. Registrar's Signature <b>James B. Aponte</b>			31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30592

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARVEY ARMACOST</b>							2. Date of Death Month Day Year <b>SEPTEMBER 21 2006</b>			3. Time of Death <b>4:39 A M</b>		
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW CARE CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>BALTIMORE CITY</b>					
Funeral Director	5. Social Security Number <b>216-16-6031</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>89 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Sept. 5, 1917</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <b>Yes</b> 2 <b>No</b>												
	10e. Street and Number <b>6525 O'Donnell Street</b>				10f. Zip Code <b>21224</b>			10g. Citizen of What Country? <b>U.S.A.</b>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1946</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>			16b. Kind of Business/Industry <b>Anchor Motor Freight</b>					
	17. Father's Name (First, Middle, Last) <b>Harvey S. Armacost</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Bernice Audrey Stifler</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Sally Armacost- Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6525 O'Donnell Street Baltimore, Maryland 21224</b>							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Hilltop Service Corp.</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>			Date <b>9/23/06</b>	20c. Location - City or Town, State <b>Towson, Maryland</b>				
	21. Signature of Funeral Service Licensee <b>Heather Clark</b>												
	22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk <b>7922 Wise Avenue Dundalk, Maryland 21222</b>												
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											Approximate Interval Between Onset and Death	
	<p>a. <b>DEMENTIA</b> Due to (or as a consequence of):</p> <p>b. <b>CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>												
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
												24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
												24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>SEPTEMBER 21 2006</b>			28b. Time of Injury <b>M</b>			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how injury occurred				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)												
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	29b. Signature and title of certifier <b>Anirudh Sridharan MD</b>												
	29c. License number <b>D0063164</b>												
	29d. Date signed (Month, Day, Year) <b>SEPTEMBER 21, 2006</b>												
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANIRUDH SRIDHARAN 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 21224</b>												
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>[Signature]</b>										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, W.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

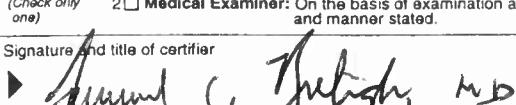
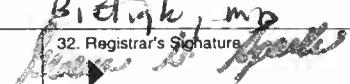
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30593

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year	3. Time of Death
	EMA R AYUB					September 24 2006	12:15 PM
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death
	Baltimore Washington Medical Ctr			Glen Burnie			Anne Arundel
To Be Completed by Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	5912-15-7520	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	57 Yrs.			6/15/1949	Mexico
Usual Residence of Decedent							
MARYLAND	10b. County	10c. City, Town or Location					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
ANNE ARUNDEL			GLEN BURNIE				
10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?	
1620 BEDFORD RD.				21061		MEXICO	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: MEXICAN			14. Race - American Indian, Black, White, etc. Specify: HISPANIC
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced							
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry
Elementary/Secondary (0-12)		College (1-4 or 5+)		HOMEMAKER			OWN HOME
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)		
MIQUEL ROMERO					AMADA AYUB		
19a. Informant's Name/Relationship (Type, Print)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
SAIB PASTOR ROMERO / SON					18303 CORNFLOWER RD., BOYDS, MD 20841		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State	
		METRO CREMATORY, INC.			SEPT. 26, 2006	CATONSVILLE, MARYLAND	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
a. Due to (or as a consequence of): Metastatic gallbladder carcinoma							
b. Due to (or as a consequence of): Bowel obstruction							
c. Due to (or as a consequence of): Pneumonia							
d. Approximate Interval Between Onset and Death 4 months							
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 							
29c. License number D0057659							
29d. Date signed (Month, Day, Year) September 26, 2006							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel C. Gutknecht, MD 305 Hospital Drive Glen Burnie, MD 21061							
31. Date filed (Month, Day, Year) SEP 27 2006							
32. Registrar's Signature 							

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important! If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

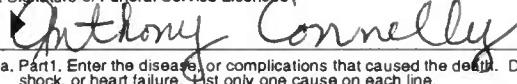
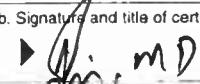
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30594

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death	
	John J. Ambot			September 25, 2006			8:30 AM			
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
	Manor Care - Rossville			Rosedale			Baltimore			
Usual Residence of Decedent										
Maryland	Baltimore	10c. City, Town or Location			Dundalk				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?			
7724 Wynbrook Road				21224			USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			14. Race - American Indian, Black, White, etc. Specify: White		
Elementary/Secondary (0-12) 12 years		College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder			16b. Kind of Business/Industry Local Union 148		
17. Father's Name (First, Middle, Last) Boles Ambot					18. Mother's Name (First, Middle, Maiden Surname) Monica Bogdanska					
19a. Informant's Name/Relationship (Type, Print) Deborah A. Marinelli Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1609 Burnfield Road, Baltimore, Maryland 21237					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith			Date September 28, 2006		20c. Location - City or Town, State Rosedale, MD.			
21. Signature of Funeral Service Licensee 										
22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMENITIA										
Approximate Interval Between Onset and Death										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
a. Due to (or as a consequence of): DEMENITIA										
b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. _____										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number D57727			29d. Date signed (Month, Day, Year) 9/26/06		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Narendar Shetty 2 Market Place • Dundalk • MD 21222										
31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30595

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important if Item 27 is marked other than "natural", or if Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<b>JOHN A. H. ANDREWS</b>		SEPTEMBER 23, 2006		12:30 PM
4a. Facility Name (If not institution, give street and number) <b>1927 ARWELL COURT</b>		4b. City, Town, or Location of Death <b>SEVERN</b>		4c. County of Death <b>ANNE ARUNDEL</b>
5. Social Security Number <b>239-74-9837</b>		6. Sex <b>M</b>		7. Age (In yrs. last birthday) <b>61 Yrs.</b>
		If Under 1 Year Months Days Hours Min.		
				8. Date of Birth (Month, Day, Year) <b>09-01-1945</b>
				9. Birthplace (State or Foreign Country) <b>NORTH CAROLINA</b>
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
10e. Street and Number <b>1927 ARWELL CT.</b>		10f. Zip Code <b>21144</b>		10g. Citizen of What Country? <b>UNITED STATES</b>
11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> If Yes, Give Year or Dates: <b>'64-'69</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>
				14. Race - American Indian, Black, White, etc. <b>Specify: BLACK</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 2 ADMINISTRATIVE ASSISTANT</b>		16b. Kind of Business/Industry <b>DENTAL</b>
17. Father's Name (First, Middle, Last) <b>EMMANUAL ANDREWS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>NANNIE LOBEE</b>		
19a. Informant's Name/Relationship (Type, Print) <b>PAULA ANDREWS / WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1927 ARWELL CT., SEVERN, MARYLAND 21144</b>		
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> <b>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CROWNSVILLE MD VET. CEM. 2006</b>		20c. Date <b>SEPT. 28</b> Location - City or Town, State <b>CROWNSVILLE, MARYLAND</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>KIRKLEY-RUDDICK FUNERAL HOME, P.A.</b> <b>421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>PANCREATIC CANCER with Metastasis</b>		Approximate Interval Between Onset and Death <b>2 years</b>
{		23c. Due to (or as a consequence of): <b>RENAL FAILURE</b>		6 weeks
{		23d. Due to (or as a consequence of): <b>CONGESTIVE HEART FAILURE</b>		12 weeks
{		23e. Due to (or as a consequence of): <b>failure to thrive</b>		6 months
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown</b>		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>		
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>		
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day Year) <b>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b>		28b. Time of Injury <b>M</b> 28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. Signature and title of certifier 		29c. License number <b>D-0052205</b> 29d. Date signed (Month, Day, Year) <b>09/27/06</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PRATIBHA SHARMA 3001 SOUTH HANOVER STREET, BALTIMORE MD 21225</b>		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

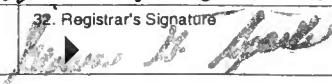
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30596

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edward J. Bruinsma</b>							2. Date of Death Month <b>Sept</b> Day <b>8</b> Year <b>2006</b>	3. Time of Death <b>0645 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Baltimore-Washington Medical Center</b>			4b. City, Town, or Location of Death <b>Glen Burnie</b>			4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>030-22-2538</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>May 18, 1929</b>	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Glen Burnie</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>7877 Americana Circle</b>				10f. Zip Code <b>21060</b>			10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>U.S. Army - Retired</b>			16b. Kind of Business/Industry <b>Military</b>		
	17. Father's Name (First, Middle, Last) <b>(unknown)</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>(unknown)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Dayeon L. Bruinsma / Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1703 Fawn Way, Finksburg, Maryland 21048</b>			
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>			Date <b>September</b>	20c. Location - City or Town, State <b>Catonsville, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b>								
	Approximate Interval Between Onset and Death								
	b. Due to (or as a consequence of): <b>Acute Renal Failure</b>								
	c. Due to (or as a consequence of): <b>Congestive Heart Failure</b>								
	d. Due to (or as a consequence of): <b>Coronary Artery Disease</b>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								
	29c. License number <b>D 51596</b>								
	29d. Date signed (Month, Day, Year) <b>September 23<sup>rd</sup> 2006</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K. Ambalavanan 7845 Oakwood Road, 103, Glen Burnie, MD 21061</b>								
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>								
	32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached (for use as the burial-transit permit).

State  
Registrar

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30597

**1- For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 2105 hrs
<b>Herbert D. Battle</b>		September 25, 2006

**Funeral Director**

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
University Hospital	Baltimore					
5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
215-34-0733	XXM 2 <input type="checkbox"/> F	69 Yrs.	Months	Days	Sep. 23, 1937	Maryland

Baltimore, MD 21215-0036  
 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
MD	Baltimore	Glyndon	
10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
26 Saint Paul Ave. P.O. Box 119	21071	U.S.A.	

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 <input type="checkbox"/> No If Yes, Give Year of Dates Korea	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes XX No specify	14. Race - American Indian, Black, White, etc. Specify Black
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10	16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) College (1-4 or 5+) Truck Driver	16b. Kind of Business/Industry Transportation
---	--	--

17. Father's Name (First, Middle, Last) <b>Joseph Battle, Sr.</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Horsey</b>
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19a. Informant's Name/Relationship (Type, Print) <b>Christine Battle / Daughter</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Saint Paul Ave. P.O. Box 119 Glyndon, MD 21071
--	--

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery</b>	Date	20c. Location - City or Town, State <b>Owings Mills, MD</b>
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21. Signature of Funeral Service Licensee <i>Michael Turner</i>	22. Name and Address of Facility <b>Eckhardt Funeral Chapel P.A.</b> 11605 Reisterstown Rd. Owings Mills, MD 21117
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**Physician/  
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute rupture abdominal aortic aneurysm complicating Atherosclerotic cardiovascular disease</b>	Approximate Interval Between Onset and Death
a. Due to (or as a consequence of):	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED <b>item#23a,27,perme g860 10/11/06 TT</b>
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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29b. Signature and title of certifier <i>Ana Rubio</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 26, 2006
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30. Name and address of person who completed cause of death (Item 23a) <b>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>
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31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>	32. Registrar's Signature <i>Herbert D. Battle</i>
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**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**State Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

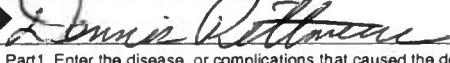
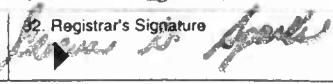
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30598

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALLAN STEWART BIRD</b>				2. Date of Death Month Day Year <b>September 23, 2006</b>	3. Time of Death 11:42 AM
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>	4c. County of Death		
Funeral Director	5. Social Security Number <b>012-26-3361</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>Oct. 21, 1935</b>	9. Birthplace (State or Foreign Country) <b>MA</b>	
To Be Completed by Funeral Director	10a. State <b>NV</b> 10b. County <b>Clark</b> 10c. City, Town or Location <b>North Las Vegas</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>818 West Brooks Avenue</b>		10f. Zip Code <b>89030</b>	10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Elementary/Secondary (0-12) 12</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Businessman</b>	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>College (1-4 or 5+) 5+</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Businessman</b>	16b. Kind of Business/Industry <b>Real Estate</b>			
	17. Father's Name (First, Middle, Last) <b>Philip Bird</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Korn</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Judith Bird (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5569 Coyote Ct., Carlsbad, CA 92010</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Mount Sinai Memorial Park</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Sinai Memorial Park</b>	Date <b>9-27-06</b>	20c. Location - City or Town, State <b>Los Angeles, CA</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Mt. Sinai Mortuary <b>5960 Forest Lawn Drive, Los Angeles, CA 90068</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>a. multi-organ system failure</b> Due to (or as a consequence of): <b>b. aspiration pneumonitis</b> Due to (or as a consequence of): <b>c. carcinoma of the pancreas</b> Due to (or as a consequence of):  d.					Approximate Interval Between Onset and Death <b>18 hours</b> <b>18 hours</b> <b>6 weeks</b>
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Dther (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>cosmopolitan pneumonia</b>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year) <b>M</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <b>Theresa Lynn Hartman MD</b>				
	29c. License number <b>Maryland DS8613</b>	29d. Date signed (Month, Day, Year) <b>September 23, 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TERESA LYNN HARTMAN 600 NORTH WOLFE STREET BALTIMORE MD 21287</b>	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>				
	32. Registrar's Signature 					

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30599

1. For State  
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Amanda Susan Blackett</b>				2. Date of Death Month Day Year <b>September 22, 2006</b>	3. Time of Death 2331 hrs
	4a. Facility Name (if not institution, give street and number) <b>Harbor Hospital Center</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>212-21-2436</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>18</b> Yrs.	If Under 1 Year Months Days Hours Min. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	8. Date of Birth (MM/DD/YYYY) <b>May 2, 1988</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b>				10c. City, Town or Location <b>Pasadena</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>8561 Chris Court</b>			10f. Zip Code <b>21122</b>	10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify <b>White</b>	
Baltimore, MD 21215-0036 <small>permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</small>	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Transporter</b>		16b. Kind of Business/Industry <b>Medical</b>	
	17. Father's Name (First, Middle, Last) <b>Gerald Blackett</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Cynthia Bokman</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Cynthia Blackett / Mother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8561 Chris Court, Pasadena MD 21122</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify <i>401411</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Mem. Park</b>	Date <b>Sept. 29, 2006</b>	20c. Location - City or Town, State <b>Sykesville, MD</b>
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Patricia Aronica-Pollak</i>			22. Name and Address of Facility <b>Singleton Funeral Home, P.A.</b> <b>1 Second Avenue SW Glen Burnie, MD 21061</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death		
a. <b>Multiple Injuries</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.						
<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED <small>IF FEMALE:</small> 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth      2 <input type="checkbox"/> Fetal death      3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death      5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Sep 22, 2006</b>		28b. Time of Injury <b>2242 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Passenger auto fixed object collision</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>Street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2400 Hawkins Point Rd., Baltimore, MD</b>		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>Patricia Aronica-Pollak</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 23, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) <b>Patricia Aronica-Pollak MD. Assistant Medical Examiner</b>		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b> 32. Registrar's Signature <i>Patricia Aronica-Pollak</i>				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death2006 30600  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LOUISE BUTLER</b>				2. Date of Death Month <b>9</b> Day <b>23</b> Year <b>2006</b>	3. Time of Death <b>9:56a M</b>		
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health N.H.</b>		4b. City, Town, or Location of Death <b>Glen Burnie</b>			4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>216-28-0116</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months <b>86</b>	If Under 24 Hrs. Hours <b>00</b>	8. Date of Birth (Month, Day, Year) <b>5-8-20</b>	9. Birthplace (State or Foreign Country) <b>Va.</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>NA</b> 10c. City, Town or Location <b>Baltimore</b>						10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
	10e. Street and Number <b>1830 N. Washington Street</b>			10f. Zip Code <b>21213</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates: <b>Year or Dates:</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8th grade</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Unemployed</b>	16b. Kind of Business/Industry <b>NA</b>					
	17. Father's Name (First, Middle, Last) <b>Unkn</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Unkn Garnes</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Karl Kirby Son</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 Warfield Rd., Glen Burnie, Md. 21060</b>			Date <b>9-27-06</b>	20c. Location - City or Town, State <b>Anne Arundel Co., Md.</b>		
Physician /Medical Examiner	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cem.</b>	20c. Location - City or Town, State <b>March F.H. East 1101 E. North Ave, Baltimore, Md. 21202</b>					
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <b>Severe dehydration</b>							
	b. Due to (or as a consequence of): <b>Malnutrition</b>							
	c. Due to (or as a consequence of): <b>Alzheimer's Dementia</b>							
	d.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>	23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>	
							24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>						
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <b>M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred			
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>							
	29b. Signature and title of certifier <b>Physician</b>	29c. License number <b>D0056950</b>			29d. Date signed (Month, Day, Year) <b>September 26, 2006</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nnaemeka Agajelu 8094 Edwin Raynor Blvd Suite A Pasadena MD 21122</b>							
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>	32. Registrar's Signature <b>Ron B. Gable</b>						

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30601

## Certificate of Death

Rag. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Jean Benick</b>				2. Date of Death Month Day Year <b>September 26, 2006</b>	3. Time of Death 3:40 AM	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Eldercare - Heritage Center</b>		4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>178-24-6681</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>November 20, 1929</b>	9. Birthplace (State or Foreign Country) <b>PA.</b>	
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Edgemere</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>4505 Sandwood Road</b>		10f. Zip Code <b>21219</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Computer Operator</b>		16b. Kind of Business/Industry <b>College</b>		
	17. Father's Name (First, Middle, Last) <b>Adam John Lutinsky</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Mary Voskus</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Denise M. Flohr Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3213 Canterbury Lane, Fallston, MD. 21047</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart Of Jesus Cem.</b>		Date <b>September 29, 2006</b>	20c. Location - City or Town, State <b>Dundalk, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Anthony Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter underlying cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death		
	{		a. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):				
	{		b. <b>DIABETES MELLITUS</b> Due to (or as a consequence of):				
	{		c. <b>MALNUTRITION</b> Due to (or as a consequence of):				
	{		d. <b>DEMENTIA</b>				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>J27188</b>		29d. Date signed (Month, Day, Year) <b>9/26/06</b>		
	29b. Signature and title of certifier <b>Savinder (C) Telle 40</b>		32. Registrar's Signature <b>Savinder (C) Telle 40</b>		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Savinder (C) Telle 40 Maude Place Dundalk 40 21222</b>						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State  
Registrar

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No.

2006 30602

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

Kimberly Ann Beecher

2. Date of Death

Month

Day

Year

1512 hrs

**Funeral  
Director**4a. Facility Name (if not institution, give street and number)  
Johns Hopkins Bayview Medical Center4b. City, Town, or Location of Death  
Baltimore

4c. County of Death

5. Social Security Number  
220-92-1251

6. Sex

1  M2  F7. Age (In yrs. last birthday)  
42 Yrs.If Under 1 Year  
Months Days Hours Min.8. Date of Birth (MM/DD/YYYY)  
April 16, 19649. Birthplace (State or  
Foreign  
Country)  
MD.

Usual Residence of Decedent

10a. State  
MD.10b. County  
Baltimore10c. City, Town or Location  
Dundalk10d. Inside City Limits  
1  Yes 2  No10e. Street and Number  
93 Kinship Road10f. Zip Code  
2122210g. Citizen of What Country?  
USA

11. Marital Status

1  Never Married  
2  Married3  Widowed  
4  Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1  Yes  
2  NoIf Yes, Give Year  
or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1  Yes  
2  No  
Specify:14. Race - American Indian, Black,  
White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

1 year

16a. Decedent's Usual Occupation (Give kind of work done  
during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Howell

19a. Informant's Name/Relationship (Type, Print)

Gregory N. Beecher Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

93 Kinship Road, Dundalk, MD. 21222

20a. Method of Disposition

1  Burial  
2  Cremation  
3  Removal from State4  Donation  
5  Other Specify:20b. Place of Disposition (Name of cemetery,  
crematory or other place)

Bayview Crematory

Date  
September  
29, 200620c. Location - City or Town, State  
Baltimore City, MD.

21. Signature of Funeral Service Licensee

Anthony Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.  
7110 Sollers Point Road, Dundalk, MD. 21222

Baltimore, MD 21215-0036

 Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

 To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial - transit
**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact gunshot wound to head

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED item#23a,27,28a-f,perME,g860, 10/12/06 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes  
2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth  
2  Fetal death  
3  Ectopic pregnancy  
4  Pregnant at time of  
5  Death  
6  Other (Specify)  
g  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes  
2  No  
3  Probably  
4  Unknown

25. Was case referred to medical examiner?

1  Yes  
2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient  
2  ER/Outpatient  
3  DOA  
Other: 4  Nursing Home  
5  Residence  
6  Other:

27. Manner of Death

1  Natural2  Accident3  Suicide4  Homicide5  Pending Investigation6  Could not be determined

28a. Date of Injury (Month, Day, Year)

Fnd 9/24/2006

28b. Time of Injury

unk

28c. Injury at Work?

1  Yes  
2  No

28d. Describe how injury occurred

subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) other-scene

28f. Location (Street and Number or Rural Route Number, City or Town, State)

93 Kinship Rd  
Baltimore, MD

29a. Certifier (Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Zabiullah Ali, M.D. Assistant Medical Examiner

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 25, 2006

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

SEP 27 2006

32. Registrar's Signature  
Leanne B. Spangler**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30603  
Reg. No.

1-  
For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert M. Bowie</b>							2. Date of Death Month 09	Day 24	Year 2006	3. Time of Death 7:00a M
	4a. Facility Name (If not institution, give street and number) <b>1733 N. Ellamont Street</b>				4b. City, Town, or Location of Death <b>21216 (Baltimore City)</b>			4c. County of Death <b>n/a</b>			
Funeral Director	5. Social Security Number <b>579-20-0472</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>11/27/1911</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
	Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore City</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>1733 N. Ellamont Street</b>				10f. Zip Code <b>21216</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>unknown</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Internal Revenue Service</b>			16b. Kind of Business/Industry <b>Federal Government</b>			
	17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Genevieve Wilson</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Sylvia M. Teal / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4004 Rosecrest Avenue; Baltimore, Maryland 21215</b>						
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Woodlawn Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		Date <b>09/28/2006</b>	20c. Location - City or Town, State <b>Woodlawn, Maryland</b>					
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Skendera Jones</b>				22. Name and Address of Facility <b>Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 21217</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Due to (or as a consequence of): <b>Acute myocardial infarction</b>			Approximate Interval Between Onset and Death <b>2 hrs.</b>			
					23c. Due to (or as a consequence of): <b>Arteriosclerotic cardiovascular disease</b>			<b>many years</b>			
					23d. Date of delivery Month Day Year						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Stroke Multi-infarct dementia Peripheral vascular disease</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
					23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24a. Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			24b. Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
					24c. Date of Death (Check only one) <b>09/26/2006</b>						
					24d. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			24e. Date of Injury (Month, Day Year) <b>M</b>			
					24f. Time of Injury <b>M</b>			24g. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24h. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>			24i. Describe how injury occurred			
					24j. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, MD</b>						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D0052847</b>			29d. Date signed (Month, Day, Year) <b>09/26/2006</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Leslie S Robinson, M.D. 295. Paca St. Baltimore MD 21201</b>				32. Registrar's Signature <b>Leslie S. Robinson</b>						
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>				33. Registrar's Signature <b>Leslie S. Robinson</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Item 23a or 28-a show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30604

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Fannie M. Brown</b>		2. Date of Death Month Day Year <b>September 11 2006</b>	3. Time of Death 8:30A M
4a. Facility Name (If not institution, give street and number) <b>7700 Quill Point Dr.</b>		4b. City, Town, or Location of Death <b>Bowie</b>	4c. County of Death <b>Prince George's</b>
5. Social Security Number <b>406-46-6537</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>July 14 1920</b>
Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Bowie</b>
10e. Street and Number <b>7700 Quill Point Dr.</b>		10f. Zip Code <b>20720</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates: <b>12th</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>	16b. Kind of Business/Industry <b>Teacher</b>	16c. Date of Death <b>9-15-06</b>
17. Father's Name (First, Middle, Last) <b>Oscar Lawson</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Lula Gordon</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Rhonda Brown (Daughter)</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7700 Quill Point Dr. Bowie, Md. 20720</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Memorial Gardens</b>	20b. Place of Disposition (Name of cemetery, funeral home, other place) <b>Memorial Gardens</b>	Date <b>9-15-06</b>	20c. Location - City or Town, State <b>Annapolis, Md.</b>
21. Signature of Funeral Service Licensee <b>Larry H. Reese m00483</b>	22. Name and Address of Facility <b>Wm. Reese &amp; Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Acute myocardial infarction</b>	Approximate Interval Between Onset and Death <b>sudden</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): <b>Acute myocardial infarction</b>		
	b. Due to (or as a consequence of):		
	c. Due to (or as a consequence of):		
	d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic obstructive pulmonary disease, sleep apnea and degenerative arthritis</b>	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
29b. Signature and title of certifier <b>Peter Schissler</b>	29c. License number <b>022780</b>	29d. Date signed (Month, Day, Year) <b>9/19/2006</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Schissler M.D. 7500 Greenway Center Suite 430 Greenbelt, Md. 20770</b>			
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>	32. Registrar's Signature <b>Laura R. Parker</b>		

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30605  
Certificate of Death

Reg. No.

1 - For  
State  
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year			3. Time of Death	
	<i>John Davis Chase SR.</i>			<i>September 25, 2006</i>			<i>9:00 PM</i>	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
	<i>Maryland General Hospital</i>			<i>Baltimore City</i>			<i>N/A</i>	
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs, last birthday) <i>88</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <i>April 5, 1918</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent			10c. City, Town or Location <i>Baltimore City</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <i>MD</i>	10b. County <i>N/A</i>	10e. Street and Number <i>2634 Edmondson Ave</i>			10f. Zip Code <i>21223</i>	10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1948</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) <i>10th</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>POLICE OFFICER</i>			16b. Kind of Business/Industry <i>An Officer Police</i>				
Elementary/Secondary (0-12) <i>N/A</i>	College (1-4 or 5+)	17. Father's Name (First, Middle, Last) <i>John Wesley Cooley Chase</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Minnie MacRae</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Sharon Marie Chase - daughter</i>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2634 Edmondson Ave. Baltimore, MD 21223</i>			Date <i>9-30-06</i>			20c. Location - City or Town, State <i>Baltimore, MD</i>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Nancy M. Cooley</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>London Park Cemetery</i>			22. Name and Address of Facility <i>3405 W Franklin St. Nancy M. Cooley Funeral Service Baltimore, MD 21223</i>				
21. Signature of Funeral Service Licensee <i>Nancy M. Cooley</i>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the manner of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Pneumonia</i>			Approximate Interval Between Onset and Death <i>Unknown</i>				
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>DR. Antonio De Gorordo</i>			29c. License number <i>89569</i>		29d. Date signed (Month, Day, Year) <i>September 26, 2006</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DR. Antonio De Gorordo</i>				31. Date filed (Month, Day, Year) <i>SEP 27 2006</i>				
32. Registrar's Signature <i>Leanne B. Jones</i>								

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30606

1. For State  
Registrar**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director**

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death 1843 hrs	
<i>Vanessa Cooper</i>		September 23, 2006					
4a. Facility Name (if not institution, give street and number) <i>Maryland General Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>N/A</i>	
5. Social Security Number <i>214-72-8307</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>45</i>		8. Date of Birth (MM/DD/YYYY) <i>Nov. 9, 1960</i>	
				Yrs. Months Days Hours Min.		9. Birthplace (State or Foreign Country) <i>Md.</i>	
10a. State <i>Md.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>			
10e. Street and Number <i>1400 Eutaw Place</i>		10f. Zip Code <i>21217</i>				10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>If Yes, Give Year or Dates:</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: <i>specify:</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i>		College (1-4 or 5+) <i>0</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Nursing Assistant</i>			
17. Father's Name (First, Middle, Last) <i>Edward Cooper</i>		18 Mother's Name (First, Middle, Maiden Surname) <i>Eloise McCullum</i>				16b. Kind of Business/Industry <i>Federal Hill Nsg. Home</i>	
19a. Informant's Name/Relationship (Type, Pri.) <i>Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Ms. Nakava Silvers 3600 Plateau Ave. Baltimore, Md. 21207</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify <i>Joseph L. Russ</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion</i>		Date <i>9/30/2006</i>		20c. Location - City or Town, State <i>Lansdowne, Md.</i>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Bilateral pneumonia</i>		Approximate Interval Between Onset and Death					
a. Due to (or as a consequence of): <i>Bilateral pneumonia</i>							
b. Due to (or as a consequence of): <i></i>							
c. Due to (or as a consequence of): <i></i>							
d. <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED item#23a, PII,27,perME,g860, 10/19/06 TT							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) g <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cocaine use; renal failure</i>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other:				23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Patricia Aronica-Pollak</i>		29c. License number <i>O.C.M.E.</i>				29d. Date signed (Month, Day, Year) <i>September 24, 2006</i>	
30. Name and address of person who completed cause of death (Item 23a) <i>Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</i>							
31. Date filed (Month, Day, Year) <i>SEP 27 2006</i>		32. Registrar's Signature <i>Patricia Aronica-Pollak</i>					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30607

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Hezekiah Carr, Jr.</i>				2. Date of Death Month 09 Day 24 Year 2006	3. Time of Death 12:52 PM		
	4a. Facility Name (If not institution, give street and number) <i>Howard County Hospital</i>		4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>			
Funeral Director	5. Social Security Number <i>225-18-7883</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>86 Yrs.</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>12-21-1919</i>	9. Birthplace (State or Foreign Country) <i>VA</i>	
	10a. State MD		10b. County <i>Howard</i>	10c. City, Town or Location <i>Columbia</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <i>5486 Wild Lilac</i>			10f. Zip Code <i>Columbia</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>9th</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <input checked="" type="checkbox"/> African-American	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+)</i>		16b. Kind of Business/Industry <i>Chauffer</i>			
	17. Father's Name (First, Middle, Last) <i>Hezekiah Carr Sr.</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Viola Paddy</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Tyrone Carr/ Son</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5486 Wild Lilac, Columbia, MD 21045</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Paddy Family Cem. 10/01/06</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Onancock, VA</i>		Date	20c. Location - City or Town, State <i>Wylie F/H P.A. of Falto. Co</i>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>9200 Liberty Rd., Randallstown, MD 21133</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Septic shock due to Pneumonia</i>							Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>respiratory failure due to Pneumonia</i>							
	a. Due to (or as a consequence of): <i>Septic shock due to Pneumonia</i>							
	b. Due to (or as a consequence of): <i>respiratory failure due to Pneumonia</i>							
	c. Due to (or as a consequence of): <i></i>							
	d. _____							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>[Signature] MD</i>							
	29c. License number <i>DOCS3709</i>							
	29d. Date signed (Month, Day, Year) <i>9/25/06</i>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Ron Chapman</i> <i>Robert Fox Lane</i> <i>SIC # 210</i> <i>Bowie MD</i> <i>20713</i>							
	31. Date filed (Month, Day, Year) <i>SEP 27 2006</i>		32. Registrar's Signature <i>James B. Smith</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial/transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30608

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lucille C. Crizer</b>					2. Date of Death Month Day Year <b>Sept. 24, 2006</b>	3. Time of Death <b>9:15 a.m.</b>
	4a. Facility Name (If not institution, give street and number) <b>1918 Marsdale Rd.</b>			4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-32-2949</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 3, 1935</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>
To Be Completed by Funeral Director	10a. State <b>Md.</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Dundalk</b>
	10e. Street and Number <b>1918 Marsdale Rd.</b>			10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Housewife</b>		16b. Kind of Business/Industry <b>Home</b>		
	17. Father's Name (First, Middle, Last) <b>James August Hess</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ada E. Edelmann</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Edward W. Crizer</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>husband 1918 Marsdale Rd. Dundalk Md. 21222</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cem.</b>		Date <b>Sept. 28, 2006</b>	20c. Location - City or Town, State <b>Baltimore</b>	
	21. Signature of Funeral Service Licensee <b>Anthony C. Connelly</b>				22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death		
	<p>a. Due to (or as a consequence of): <b>Acute myocardial infarction</b></p> <p>b. Due to (or as a consequence of): <b>Type II Diabetes Mellitus</b></p> <p>c. Due to (or as a consequence of): <b>with High Blood Pressure</b></p> <p>d. Due to (or as a consequence of): <b>and Hyperlipidemia</b></p>				<b>&gt;5 yrs</b>		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypothyroidism; Chronic Back Pain; History Peptic ulcer disease with GI bleeding in Remote Past</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29b. Signature and title of certifier <b>Michael A. Hyland</b>		29c. License number <b>10027093</b>		29d. Date signed (Month, Day, Year) <b>9/25/2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael A. Hyland 6530 Northern Boulevard 1206</b>		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>James M. Foster</b>		

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For  
State  
Registrar

State of Maryland Department of Health and Mental Hygiene 2006 30609  
Amend item#19a-b, per H.H. 6859, 9/27/06 Certificate of Death Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year				3. Time of Death		
	George OTIS Christian				September 22 2006				1:30 AM		
Funeral Director	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital				4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore		
	5. Social Security Number 224-14-6766		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) June 12, 1922	9. Birthplace (State or Foreign Country) V.A.			
Usual Residence of Decedent 10a. State M.D 10b. County N/A 10c. City, Town or Location Baltimore											10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 5502 Hamilton Ave				10f. Zip Code 21206				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK				14. Race - American Indian, Black, White, etc.			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) None		16b. Kind of Business/Industry Truck Driver				Driving Trucks			
17. Father's Name (First, Middle, Last) Abner Christian				18. Mother's Name (First, Middle, Maiden Surname) Ruth Pinkney							
19a. Informant's Name/Relationship (Type, Print) Virginia HENRY Christian				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5502 Hamilton Ave Baltimore MD 21206				MD			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Earth Mem.				Date Sept. 29 2006			
21. Signature of Funeral Service Licensee Patrick Bett				22. Name and Address of Facility Bett's Funeral Home 1220 N. Belair Line St. Baltimore MD 21213							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): Guillain Barre Syndrome											Approximate Interval Between Onset and Death
b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)				23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Suganthi Agarsamy Res 0000		29c. License number				29d. Date signed (Month, Day, Year) September 27 2006					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suganthi Agarsamy 9000 Franklin Square Drive Baltimore MD 21237											
31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature Debbie B. Spangler									

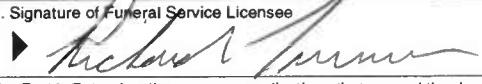
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30610

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Edward Debus</b>						2. Date of Death Month <b>September</b> Day <b>26</b> Year <b>2006</b>	3. Time of Death <b>7:30 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Saint Hospital of Baltimore</b>			4b. City, Town, or Location of Death <b>Baltimore city</b>			4c. County of Death	
Funeral Director	5. Social Security Number <b>212-20-4152</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>June 21, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Owings Mills</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number <b>137 Wengate Rd.</b>				10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Groundsman</b>			16b. Kind of Business/Industry <b>Baltimore County Board of Education</b>		
17. Father's Name (First, Middle, Last) <b>Charles E. Debus</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Grimm</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy C. Debus / Spouse</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>137 Wengate Rd. Owings Mills, MD 21117</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Evergreen Memorial Gardens</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date <b>9/29/06</b>	20c. Location - City or Town, State <b>Finksburg, MD</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD 21117</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>STROKE</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____ Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>1 day</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Hypertension</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28e. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 			29c. License number <b>RES 000</b>			29d. Date signed (Month, Day, Year) <b>September 20, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Oscar Barlow, MD, Saint Hospital of Baltimore, 2401 W. Belvedere Ave, Baltimore MD 21215</b>								
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>			32. Registrar's Signature 					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30611

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rita Ann Davis</b>				2. Date of Death Month Day Year <b>September 24, 2006</b>	3. Time of Death <b>5:25 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Genesis Elder Care Severna Park</b>		4b. City, Town, or Location of Death <b>Severna Park</b>		4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>391-30-6575</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <b>10/07/1934</b>	9. Birthplace (State or Foreign Country) <b>IL</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Glen Burnie</b>							
	10e. Street and Number <b>703 Marlboro Road</b>		10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Clerk</b>		16b. Kind of Business/Industry <b>F.B.I.</b>			
	17. Father's Name (First, Middle, Last) <b>Leo Stephen Jansen</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Valeda Rose Vanderbloomen</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Buster K. Davis / husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>703 Marlboro Road; Glen Burnie, MD 21061</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Maryland Veterans Cem</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem</b>		Date <b>09/28/2006</b>	20c. Location - City or Town, State <b>Crownsville, MD</b>		
	21. Signature of Funeral Service Licensee <b>Selena Shirk MO1479</b>			22. Name and Address of Facility <b>Singleton Funeral Home, PA</b> <b>1 Second Ave SW; Glen Burnie, MD 21061</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>Acute myocardial infarction</b>	
	<p>a. _____ Due to (or as a consequence of): <b>atherosclerotic coronary artery Disease</b></p> <p>b. _____ Due to (or as a consequence of): <b> </b></p> <p>c. _____ Due to (or as a consequence of): <b> </b></p> <p>d. _____ Due to (or as a consequence of): <b> </b></p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b> <b>Diabetes mellitus</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b> </b>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide <input type="checkbox"/> Unnatural		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>S. Ambalavanan MD</b>		29c. License number <b>D 51596</b>		29d. Date signed (Month, Day, Year) <b>September 25th 2006</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K. Ambalavanan 7845 Oakwood Road, 103, Glen Burnie, MD 21061</b>							
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>Jean B. Jacobs</b>					

Baltimore, Maryland 21215-0036

Permit Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30612

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Craig Allen Dayton</b>							2. Date of Death Month Day Year <b>September 21 2006</b>	3. Time of Death <b>4:00 P M</b>					
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>							
Funeral Director	5. Social Security Number <b>217-68-1549</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50 Yrs.</b>		If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>September 10, 1956</b>	9. Birthplace (State or Foreign Country) <b>Baltimore, Maryland</b>					
	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number <b>1651 Poles Road</b>				10f. Zip Code <b>21221</b>			10g. Citizen of What Country? <b>USA</b>						
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.						
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Shipping Person</b>		16b. Kind of Business/Industry <b>Warehausman</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Betty Lou Ahern</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Loma DeVincenz</b> sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1651 Poles Road, Essex, Maryland 21221</b>		Date <b>September 22, 2006</b>			20c. Location - City or Town, State <b>Baltimore City, MD.</b>						
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <b>Anthony Connally</b>		22. Name and Address of Facility <b>Connally Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222</b>											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acquired Immunodeficiency Syndrome</b>		Approximate Interval Between Onset and Death <b>1 week</b>									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year											
Medical Certification; To Be Completed by Physician/Medical Examiner	24. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <b>September 21, 2006</b>		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
							28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, Maryland 21218</b>					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Elliot Share D.O.</b>		29c. License number <b>H0061180</b>		29d. Date signed (Month, Day, Year) <b>September 21, 2006</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Elliot Share D.O. 201 East University Parkway Baltimore, Maryland 21218</b>		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>James A. Kelly</b>									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

06-07050

Kenneth Bernard Davis

**Please Type or Print in Black Indelible Ink**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2006 30613

**Physician/  
Medical Examiner**  
 1- For State  
Registrar

**Funeral  
Director**

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last) <b>Kenneth                    Bernard                    Davis</b>				2. Date of Death Month Day Year <b>September 18, 2006</b>				3. Time of Death 1025 hrs	
4a. Facility Name (if not institution, give street and number) <b>1243 Patterson Park</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>	
5. Social Security Number <b>216-78-0122</b>		6. Sex <b>1 X M    2   F</b>	7. Age (In yrs. last birthday) <b>47 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>	8. Date of Birth (MM/DD/YYYY) <b>11-09-1958</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>
10. Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>NA</b> 10c. City, Town or Location <b>Baltimore</b>									
10e. Street and Number <b>1243 N. Patterson Park</b>				10f. Zip Code <b>21213</b>				10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1 X Never Married    2   Married 3   Widowed    4   Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1   Yes    2 X No</b> If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1   Yes    2 X No    specify: Black</b>			14. Race - American Indian, Black, White, etc. <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)    11th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)    Disabled</b>				16b. Kind of Business/Industry <b>NA</b>	
17. Father's Name (First, Middle, Last) <b>Bernard Wilson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Claudia Davis</b>					

**To Be Completed by Physician/Medical Examiner**

19a. Informant's Name/Relationship (Type, Print) <b>Geneva Couplin Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>233 W. Coulter Street, Phila., Pa. 19144</b>	
20a. Method of Disposition <b>1   Burial    2 X Cremation    3   Removal from State 4   Donation    5   Other Specify: <i>Baltimore</i></b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cem.</b>	Date <b>9-22-06</b>
21. Signature of Funeral Service Licensee <i>Baltimore</i>		22. Name and Address of Facility <b>March F.H. East 1101 E. Borth Ave., Baltimore, Md. 21202</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Methadone intoxication</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  <b>UNPENDED</b> <b>AMENDED</b> <b>item#23a,27,28a-f,perME,g859, /9/28/06 TT</b>			
23b. Was decedent pregnant in the past 12 months? <b>1   Yes    2   No    9   Unknown</b>			
23c. If yes, outcome of pregnancy <b>1   Live birth    2   Fetal death    3   Ectopic pregnancy 4   Pregnant at time of death    5   Other (Specify) 9   Unknown</b>			
23d. Date of delivery Month Day Year			

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I				23e. Did tobacco use contribute to the cause of death? <b>1   Yes    2 X No    3   Probably    4   Unknown</b>
				24a. Was an autopsy performed? <b>1 X Yes    2   No</b>
				24b. Were autopsy findings available prior to completion of cause of death? <b>1 X Yes    2   No</b>

25. Was case referred to medical examiner? <b>1 X Yes    2   No</b>		26 Place of Death (Check only one) Hospital <b>1   Inpatient    2   ER/Outpatient    3   DOA    4   Nursing Home    5   Residence    6 X Other Scene</b>					
27. Manner of Death <b>1   Natural    5   Pending Investigation 2   Accident    6 X Could not be determined 3   Suicide    4   Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>Fnd 9/18/2006</b>	28b. Time of Injury <b>Fnd 10:15 am</b>	28c. Injury at Work? <b>1   Yes    2 X No</b>	28d. Describe how injury occurred <b>unk</b>		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>(Specify) House</b>					
		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1243 Patterson Park Baltimore, MD</b>					

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated  <b>Ana Rubid MD. Assistant Medical Examiner</b>				29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 19, 2006</b>
30. Name and address of person who completed cause of death (Item 23a) <b>Ana Rubid MD. Assistant Medical Examiner</b>		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>			
		32. Registrar's Signature <i>Ana Rubid</i>			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30614  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frederick D. Downs</b>				2. Date of Death Month Day Year <b>September 17 2006 9:59 A M</b>	3. Time of Death		
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>		4b. City, Town, or Location of Death <b>Tacoma Park</b>		4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>218-82-9850</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Dec 2 1961</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent <b>Maryland Anne Arundel</b>		10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Annapolis</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>2</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>29 W. Washington St. Apt 207</b>			10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>7th</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Dishwasher</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 7th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 0</b>	16b. Kind of Business/Industry <b>Dishwasher Restaurant</b>				
	17. Father's Name (First, Middle, Last) <b>Frederick D. Downs Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel M. Abrims</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Wendy Byrd (Godmother)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>311 Bloomsbury Square Annapolis, Md. 21401</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Larry H. Reese M00483</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>	Date <b>9-25-06</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>		
	21. Signature of Funeral Service Licensee <b>Larry H. Reese M00483</b>			22. Name and Address of Facility <b>Wm. Reese &amp; Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line <b>Immediate Cause (Final disease or condition resulting in death)</b>  <b>Cadio - pulmonary Guest</b>				Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b> a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  <b>End stage renal disease</b> <b>Mitral stenosis</b> <b>Cadio myopathy</b>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>End stage renal disease</b> <b>Mitral stenosis</b> <b>Cadio myopathy</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>DR. NASREEN KANGO</b>		29c. License number <b>56147</b>		29d. Date signed (Month, Day, Year) <b>9/17/06</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Nasreen Kango 7010 Carroll Ave. Tacoma Park, MD 20912</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>Nasreen Kango</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner shall be notified at once.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30616

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death
Howard Finney	September 20 2006				7:32 p.m.
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				4c. County of Death
Harbor Hospital	Baltimore				
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 04/08/1926
219-18-7949					9. Birthplace (State or Foreign Country) MD

Funeral Director

To Be Completed by Funeral Director

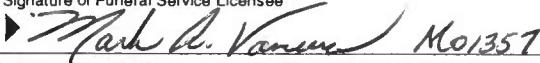
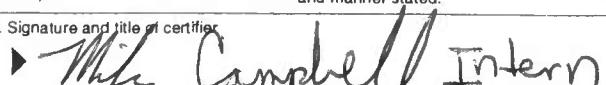
Baltimore, Maryland 21215-0036  
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Linthicum	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 705 West Maple Road	10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printer	16b. Kind of Business/Industry Printing Press		
17. Father's Name (First, Middle, Last) Howard Franklin Finney, II	18. Mother's Name (First, Middle, Maiden Surname) Mildred Kiem			
19a. Informant's Name/Relationship (Type, Print) Mr. Patrick Finney / son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Wanda Road; Linthicum, MD 21090			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park	Date 09/25/2006	20c. Location - City or Town, State Glen Burnie, MD	
21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	23b. Approximate Interval Between Onset and Death Unknown			
a. Hemorrhagic Stroke Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier  Intern			
29c. License number RES001		29d. Date signed (Month, Day, Year) September, 20 2006		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mike Campbell 3001 S. Hanover St. Baltimore MD 21225				
31. Date filed (Month, Day, Year) SEP 27 2006	32. Registrar's Signature 			

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30617

For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

LILLIAN FOSTER  
Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans-

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death		
Lillian R. Foster							SEPTEMBER 22 2006 02.50 AM					
4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death			4c. County of Death		
BALTIMORE WASHINGTON MEDICAL CENTER							GLEN BURNIE ANNE ARUNDEL					
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) May 1, 1925			9. Birthplace (State or Foreign Country) MD	
10a. State MD							10c. City, Town or Location Severn			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 8118 Quarterfield Rd.				10f. Zip Code 21144				10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook			16b. Kind of Business/Industry School					
17. Father's Name (First, Middle, Last) William Sawyer							18. Mother's Name (First, Middle, Maiden Surname) Lillian R. Rice					
19a. Informant's Name/Relationship (Type, Print) Mr. Adam Foster / Husband							19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8118 Quarterfield Rd., Severn, MD 21144					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► <i>R. Foster</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park			Date September 25	20c. Location - City or Town, State Glen Burnie, MD 2006				
21. Signature of Funeral Service Licensee ► <i>R. Foster</i>				22. Name and Address of Facility M01411			1 Second Ave. SW Singleton Funeral Home; Glen Burnie, MD 21061					

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { a. Due to (or as a consequence of): <i>Septic</i> b. Due to (or as a consequence of): <i>ACUTE RENAL FAILURE</i> c. Due to (or as a consequence of): <i>ATRIAL FIBRILLATION</i> d. _____							Approximate Interval Between Onset and Death		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		M								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29c. License number <i>MD 45149</i>				29d. Date signed (Month, Day, Year) <i>September 22 2006</i>
29b. Signature and title of certifier ► <i>R. Foster</i>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>301 Hospital Drive Glen Burnie MD 21061</i>							32. Registrar's Signature <i>R. Foster</i>				
31. Date filed (Month, Day, Year) <i>SEP 27 2006</i>							33. Date signed (Month, Day, Year)				

ORIGINAL

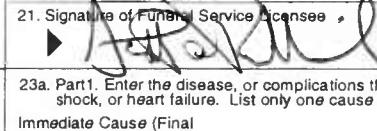
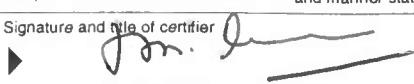
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30618

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EMILY HELEN GIBSON</b>							2. Date of Death Month Day Year <b>SEPTEMBER 23, 2006 7:50 A M</b>	3. Time of Death	
	4a. Facility Name (If not institution, give street and number) <b>MARLEY HEALTH &amp; REHAB.</b>				4b. City, Town, or Location of Death <b>GLEN BURNIE</b>			4c. County of Death <b>ANNE ARUNDEL</b>		
Funeral Director	5. Social Security Number <b>214-12-2957</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>JAN. 8, 1922</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
	Usual Residence of Decedent <b>MARYLAND ANNE ARUNDEL</b>		10c. City, Town or Location <b>GLEN BURNIE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>			10b. County <b>ANNE ARUNDEL</b>	10f. Zip Code <b>21061</b>			10g. Citizen of What Country? <b>UNITED STATES</b>		
	10e. Street and Number <b>615 NEWFIELD RD.</b>									
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>OWN HOME</b>			
17. Father's Name (First, Middle, Last) <b>FRANK MATTHEW STERNAT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CLARA LANGOHR</b>						
19a. Informant's Name/Relationship (Type, Print) <b>THOMAS GIBSON, SR. / HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>615 NEWFIELD RD. GLEN BURNIE, MD 21061</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MEADOWRIDGE MEM. PARK</b>		Date <b>SEPT. 26,</b>	20c. Location - City or Town, State <b>ELKRIDGE, MARYLAND</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>KIRKLEY-RUDDICK FUNERAL HOME, P.A.</b> <b>421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): <b>Dementia</b>					Approximate Interval Between Onset and Death <b>few months</b>	
				23c. Due to (or as a consequence of): <b>Hypertension</b>					Many years	
				23d. Due to (or as a consequence of): <b>Diabetes</b>					Many years	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23e. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					23d. Date of delivery Month Day Year	
									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <b>D 40519</b>			29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mirza Nusairee, M.D., 1401 Madison Park Drive, Glen Burnie, MD 21061</b>										
31. Date filed (Month, Day, Year) <b>SEP 27 2005</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  within 24 hours after death, it may be filed by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Important: Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2006 30619

1-  
For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
<b>Milton J. Gross, Jr.</b>		<b>September 23, 2006</b>		<b>1803 M</b>	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
<b>Good Samaritan Hospital</b>		<b>Baltimore</b>		<b>NA</b>	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Jan 10 1940</b>	9. Birthplace (State or Foreign Country) <b>VA</b>
10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>	
10e. Street and Number <b>6116 Belair Rd</b>		10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) <b>HS</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>		16b. Kind of Business/Industry <b>N/A</b>	
17. Father's Name (First, Middle, Last) <b>Milton J. Gross, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Montgomery</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Violet Keiter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1301 Walker Rd Freehand, MD 21053</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>M</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>10-2-06</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>
21. Signature of Funeral Service Licensee <b>Carolyn</b>		22. Name and Address of Facility <b>HIA 1232 Midvalley Jessup, PA 18434</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of): <b>Gastro-intestinal Bleeding</b>					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		<b>M</b>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
29b. Signature and title of certifier <b>Khan MD</b>		29c. License number <b>D 25391</b>		29d. Date signed (Month, Day, Year) <b>9-25-2006</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. KHAN 5601-Loch Raven Blvd, Baltimore MD 21239</b>					
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>Jean B. Jones</b>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
1- For Amend #7 Per FH G860 10/11/06 JH Certificate of Death 2006 30620  
State Registrar Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>W. Alan Gonnen</b>							2. Date of Death Month <b>09</b> Day <b>21</b> Year <b>06</b>			3. Time of Death <b>3:35 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>Baltimore City</b>					
Funeral Director	5. Social Security Number <b>216-52-6786</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>04/22/1948</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Timonium</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
	10e. Street and Number <b>23 Gorsch Road</b>			10f. Zip Code <b>21093</b>			10g. Citizen of What Country? <b>U.S.A.</b>						
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembly Person</b>		16b. Kind of Business/Industry <b>Gallagher Service</b>								
	17. Father's Name (First, Middle, Last) <b>Warren Carl Gonnen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Lillian MacKenzie</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Nancy Leatherman (sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12910 Manor Road - Glen Arm, Maryland 21057</b>				Date				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>E. F. Lassahn</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Michael Luth.Cem.</b>		20c. Location - City or Town, State <b>09/23/2006 Baltimore, Maryland</b>								
	21. Signature of Funeral Service Licensee <b>E. F. Lassahn</b>				22. Name and Address of Facility <b>E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087</b>								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
	Immediate Cause (Final disease or condition resulting in death) a. <b>INTRACRANIAL BLEEDING</b> Due to (or as a consequence of): b. _____ c. _____ d. _____												
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify) _____			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA DOWN'S SYNDROME</b>										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>DG 3381</b>				29d. Date signed (Month, Day, Year) <b>September 21, 06</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VIRGINIE CHEBOU GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALTIMORE, MARYLAND</b>												
	31. Date filed (Month Day Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>Jeanne J. Gonnen</b>										

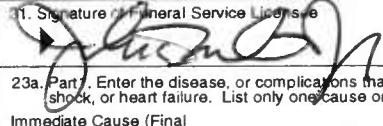
## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 200630821

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CARROLL GALINUS</b>			2. Date of Death Month Day Year <b>SEPTEMBER 22, 2006 8:50 PM</b>			3. Time of Death
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>219-40-4761</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Sept. 6, 1943</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Dundalk</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>6611 Danville Ave.</b>			10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Drywaller</b>	16b. Kind of Business/Industry <b>Construction</b>				
	17. Father's Name (First, Middle, Last) <b>Vincent Galinus</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred S. Plummer</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Karen Tyranski</b> daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2154 Bernays Dr. York Pa. 17404</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Christ Luth. Cem.</b>	Date <b>Sept. 25, 2006</b>	20c. Location - City or Town, State <b>Dundalk</b>			
Physician /Medical Examiner	21. Signature of Physician Service Licensee 			22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death			
	a. <b>SEPTICEMIA</b> Due to (or as a consequence of):						
	b. <b>END STAGE RENAL DISEASE</b> Due to (or as a consequence of):						
	c. <b>ACQUIRED IMMUNODEFICIENCY SYNDROME</b> Due to (or as a consequence of):						
	d.						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1. Natural 2. Accident 3. Suicide 4. Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	5. Pending investigation 6. Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <b>D0030355</b>	29d. Date signed (Month, Day, Year) <b>SEPTEMBER 22, 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL</b>	32. Registrar's Signature 					
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>						

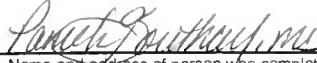
06-07137

Michael John Handzel

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No. 2006 30622

1- For State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Michael John Handzel</b>						2. Date of Death Month <b>September</b> Day <b>21</b> , Year <b>2006</b>		3. Time of Death <b>1905 hrs</b>	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>3 Main Brook Court</b>						4b. City, Town, or Location of Death <b>Reisterstown</b>		4c. County of Death <b>Baltimore County</b>	
To Be Completed by Funeral Director		5. Social Security Number <b>080-60-0397</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>33</b> Yrs	If Under 1 Year Months <input type="text"/> Days <input type="text"/>		If Under 24 Hrs. Hours <input type="text"/> Min. <input type="text"/>		8. Date of Birth (MM/DD/YYYY) <b>Oct. 14, 1972</b>	
To Be Completed by Funeral Director		9. Birthplace (State or Foreign Country) <b>New York</b>						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Reisterstown</b>						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		10e. Street and Number <b>3 Main Brook Court</b>				10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No <small>If Yes, Give Year or Dates:</small>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:		14. Race - American Indian, Black, White, etc. <small>Specify: White</small>			
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) <b>Maintenance</b>			16b. Kind of Business/Industry <b>Housing</b>		
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>Edward Richard Price</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Joanne Victoria Handzel</b>					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>Jeffrey Badger (Brother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11090 Bell Hill Rd., Deerfield, NY 13502</b>					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>9/27/06</b>		20c. Location - City or Town, State <b>Alexandria, VA</b>			
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Heintz Funeral Service</b> <b>1517 Whitesboro St., Utica, NY 13502</b>							
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)						a. <b>Narcotic (Hydrocodone) and alcohol intoxication</b> <small>Due to (or as a consequence of):</small>			
To Be Completed by Physician/Medical Examiner		b. <small>Due to (or as a consequence of):</small>									
To Be Completed by Physician/Medical Examiner		c. <small>Due to (or as a consequence of):</small>									
To Be Completed by Physician/Medical Examiner		d. <small>Due to (or as a consequence of):</small>									
To Be Completed by Physician/Medical Examiner		<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED		item#23a,27,28a-f,perME,g860, 10/12/06 TT					
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>					
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene			
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Fnd 9/21/2006</b>		28b. Time of Injury <b>Fnd 6:54 pm</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>House</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3 Main Brook Court Reisterstown, MD</b>			
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated									
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 22, 2006</b>			
State Registrar		30. Name and address of person who completed cause of death (Item 23a) <b>Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>									
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature 							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 2006 30623  
Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Louise Harris</b>							2. Date of Death Month Day Year <b>Sept. 24, 2006</b>	3. Time of Death <b>10:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care-Rossville</b>			4b. City, Town, or Location of Death <b>Rossville</b>			4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>218-32-7982</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Mar. 4, 1919</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Harford</b>			10c. City, Town or Location <b>Abingdon</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>3827 Philadelphia Rd.</b>				10f. Zip Code <b>21009</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>7</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>						
17. Father's Name (First, Middle, Last) <b>Howard (nmn) Norton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Serina Hollingsworth</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Lloyd A. Harris/ Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1204 Pulaski Highway, Joppa, Maryland 21085</b>			Date				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>John Wesley U. M. C.</b>			20c. Location - City or Town, State <b>Abingdon, Maryland</b>				
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>McComas Funeral Home, P.A.</b> <b>1317 Cokesbury Rd., Abingdon, Maryland 21009</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b>									Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of): <b>Sepsis</b>										
b. Due to (or as a consequence of): <b>Small bowel obstruction</b>										
c. Due to (or as a consequence of):										
d. _____										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>DS6979</b>					29d. Date signed (Month, Day, Year) <b>9-26-2006</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Madai Chardon 7845 Oakwood Rd Ste 100 Glen Burnie, MD</b>										
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>			32. Registrar's Signature 							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30624

## Certificate of Death

Reg. No.

For  
State  
Registrar

1-

First, Middle, Last)

1.

Decedent's Name (First, Middle, Last)

Marvin Harry

2. Date of Death

Month

Day

Year

3. Time of Death

3:16 P M

4a.

Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Physician  
/Medical  
Examiner

5.

Social Security Number

216-42-6583

6. Sex

 M F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 24, 1942

9. Birthplace (State or Foreign Country)

MD

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

10a.

State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1  Yes  No

10e.

Street and Number

211 Solar Court

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11.

Marital Status

1  Never Married3  Widowed2  Married4  Divorced

12.

Was Decedent Ever in U.S.

1  Yes2  No

If Yes, Give

Year or Dates:

13.

Was Decedent of Hispanic Origin? (Specify Yes or No)

1  Yes2  No

Specify:

14.

Race - American Indian,

Black, White, etc.

Specify: White

15.

Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a.

Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

16b.

Kind of Business/Industry

A.A Co. Public Schools

17. Father's Name (First, Middle, Last)

Charles Harry

18. Mother's Name (First, Middle, Maiden Surname)

Doris Hesterbury

19a.

Informant's Name/Relationship (Type, Print)

Mrs. Sandra Ann Harry/Wife

19b.

Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

211 Solar Court, Pasadena MD 21122

20a.

Method of Disposition

1  Burial2  Cremation3  Removal from State4  Donation5  Other (Specify)

20b.

Place of Disposition (Name of cemetery, crematory or other place)

Sandy Mount Cem.

Date

Sept. 26,

2006

20c.

Location - City or Town, State

Finksburg, Maryland

21.

Signature of Funeral Service Licensee

Mark A. Vanum

Mo 1357

22.

Name and Address of Facility

Singleton Funeral Home, P.A.

1

Second Avenue

SW Glen Burnie, MD 21061

23a.

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cerebral hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1  Yes2  No9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth2  Fetal death3  Ectopic pregnancy4  Pregnant at time of death5  Other (Specify)9  Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes2  No3  Probably4  Unknown

24a. Was an autopsy performed?

1  Yes2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes2  No

25. Was case referred to medical examiner?

1  Yes2  No

26. Place of Death (Check only one)

1  Inpatient2  ER/Outpatient3  DOA

Other:

4  Nursing Home5  Residence6  Other (Specify)

27. Manner of Death

1  Natural2  Accident3  Suicide4  Homicide5  Pending investigation6  Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1  Yes2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Oluchi C. Ozumba

22 South Greene Street

Baltimore, MD 21201

29c. License number

15588

29d. Date signed (Month, Day, Year)

September 22, 2006

31. Date filed (Month, Day, Year)

SEP 27 2006

32. Registrar's Signature

Oluchi C. Ozumba

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30625

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Donald Ray Hicks</b>										2. Date of Death Month Day Year <b>September 25, 2006</b>	3. Time of Death <b>10:25P M</b>
		4a. Facility Name (If not institution, give street and number) <b>107 Vista Avenue</b>					4b. City, Town, or Location of Death <b>Glen Burnie</b>				4c. County of Death <b>Anne Arundel</b>		
Funeral Director		5. Social Security Number <b>223-20-0724</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>12/11/1925</b>			9. Birthplace (State or Foreign Country) <b>VA</b>			
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Glen Burnie</b>										10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>107 Vista Avenue</b>					10f. Zip Code <b>21061</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
Physician /Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>				16b. Kind of Business/Industry <b>Accounting</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>James Franklin Hicks</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Cynthia Poole</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Anna Lee Hicks / wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 Vista Avenue; Glen Burnie, MD 21061</b>						
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial</b>			Date <b>09/30/2006</b>	20c. Location - City or Town, State <b>Elkridge, MD</b>					
		21. Signature of Physician/Serviceman/Licensed Practical Nurse <i>Daljit S. Sawhney</i>					22. Name and Address of Facility <b>Singleton Funeral Home, PA</b> <b>1 Second Ave SW; Glen Burnie, MD 21061</b>						
Medical Certification: To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
		<p>a. <i>Arteriosclerosis w/ Severe Peripheral Vascular Disease</i> Due to (or as a consequence of): <i>20 yrs.</i></p> <p>b. <i>Cerebrovascular Accident</i> Due to (or as a consequence of): <i>20 yrs.</i></p> <p>c. <i>Hypertension</i> Due to (or as a consequence of): <i>multiple decubitus</i></p> <p>d.</p>											
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Renal failure</i>					23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
Medical Certification: To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D14136</b>					29d. Date signed (Month, Day, Year) <b>9/26/06</b>				
State Registrar		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Glen Burnie MD 21061</b>		32. Registrar's Signature <i>Daljit S. Sawhney</i>									
		31. Date filed (Month, Day, Year) <b>SEP 27 2005</b>											

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30626

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Par. 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

1. Decedent's Name (First, Middle, Last)		Higgins		2. Date of Death Month Day Year	3. Time of Death
Flossie				Sept. 22 2006	3:45 PM
4a. Facility Name (If not institution, give street and number)		Future Care Nursing Home		4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.	
8. Date of Birth (Month, Day, Year) May 3, 1922		9. Birthplace (State or Foreign Country) S.C.		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10e. Street and Number 501 E. Preston St.				10f. Zip Code 21202	10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) House Work	
16b. Kind of Business/Industry Cleaning Homes		17. Father's Name (First, Middle, Last) Nelson Bratton		18. Mother's Name (First, Middle, Maiden Surname) Grace Unknown	
19a. Informant's Name/Relationship (Type, Print) Kevin White		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 Drew Hill Ave Baltimore MD 21217		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		Date Sept. 22, 2006	20c. Location - City or Town, State Owings Mills MD
21. Signature of Funeral Service Licensee Dale Batts		22. Name and Address of Facility Batts Funeral Home 1129 N. Caroline St. Baltimore MD 21203		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Causes of death: La lung	
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23g. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24c. Describe how injury occurred		24d. Location (Street and Number or Rural Route Number, City or Town, State)	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	
27. Manner of Death 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 51088		29d. Date signed (Month, Day, Year) September 25, 2006	
29b. Signature and title of certifier Thaw Poow, MD FACP		29c. License number D 51088		29d. Date signed (Month, Day, Year) September 25, 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thaw Poow 351 Sir Paul Place #701 Baltimore MD 21222		31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature Anne H. Adler	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30627  
Amend item#19a, per FH, G859, 9/27/06 TT Certificate of Death Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Portia Allen Hillary</b>							2. Date of Death Month Day Year <b>September 20 2006</b>	3. Time of Death 5:35 PM		
	4a. Facility Name (If not institution, give street and number) <b>Baltimore Washington Medical Center</b>			4b. City, Town, or Location of Death <b>Glen Burnie</b>			4c. County of Death <b>Anne Arundel</b>				
Funeral Director	5. Social Security Number <b>217-52-4567</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 9 1949</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Annapolis</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1155 Madison St. Apt S3</b>			10f. Zip Code <b>21403</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>0</b> <b>Nurse</b>			16b. Kind of Business/Industry <b>Private Family</b>				
	17. Father's Name (First, Middle, Last) <b>Joseph Blake</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucille Holland</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Mister Hillary (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7623 Overhill Dr. Pasadena, Md. 21060</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>	Date <b>9-26-06</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>							
	21. Signature of Funeral Service Licensee <b>Larry H. Reese MOO483</b>				22. Name and Address of Facility <b>Wm. Reese &amp; Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b>								Approximate Interval Between Onset and Death		
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>										
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year		
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred		
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <b>George E. Wicks III MD</b>	29c. License number <b>D41365</b>	29d. Date signed (Month, Day, Year) <b>September 20, 2006</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>George E. Wicks III MD, 301 Hospital Drive, Glen Burnie, MD 21061</b>								31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>	32. Registrar's Signature <b>George E. Wicks</b>	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30628  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARION INGRAM</b>							2. Date of Death Month <b>SEPT</b> Day <b>25</b> Year <b>2006</b>	3. Time of Death <b>142 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL</b>			4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>			4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>289-48-1042</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>02-27-1932</b>	9. Birthplace (State or Foreign Country) <b>TN</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Owings Mills</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>19 Buhrstone Court</b>			10f. Zip Code <b>21117</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Widowed	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>8th</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cosmetologist</b>			16b. Kind of Business/Industry <b>Cosmetology</b>			
	17. Father's Name (First, Middle, Last) <b>Willie F. Mosley, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Amy Johnson</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Lori L. Leonard Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19 Buhrstone Ct., Owings Mills, MD 21117</b>			Date	20c. Location - City or Town, State <b>Sykesville, MD</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Lakeview Memorial</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>09/29/06</b>			21. Signature of Funeral Service Licensee <b>Vaughn C. Greene</b>			
	22. Name and address of facility <b>Vaughn C. Greene Funeral Services 8728 Liberty Rd., Randallstown, MD 21133</b>								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>STROKE</b>							Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b> <b>DIABETES MELLITUS</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year) <b>SEPT 25, 2006</b>	
	29b. Signature and title of certifier <b>KERRY JOSEPH</b>							29c. License number <b>DS8933</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KERRY JOSEPH 5401 OLDGOURT RD RANDALLSTOWN, MD 21133</b>							32. Registrar's Signature <b>Jerry A. Spotts</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>							32. Registrar's Signature	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30629

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death Hour:Minute AM/PM	
DORIS ELIZABETH JOHNSON-SMITH		SEPTEMBER 23, 2006		8:51 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
SINAI HOSPITAL of BALTIMORE		BALTIMORE CITY		N/A	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11/02/1915
219-22-7920					9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Decedent					
10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 3504 CEDARDALE ROAD		10f. Zip Code 21215		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) DOMESTIC		16b. Kind of Business/Industry DOMESTIC	
17. Father's Name (First, Middle, Last) ROBERT JOHNSON		18. Mother's Name (First, Middle, Maiden Surname) MAUDE HALL			
19a. Informant's Name/Relationship (Type, Print) MARY J. DEMORY / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 CEDARDALE ROAD, BALTIMORE, MD 21215			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEM. GARRISON FOREST		Date 9/29/06	20c. Location - City or Town, State OWINGS MILLS, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 1 hr.			
<p>a. Due to (or as a consequence of): Cardiac arrhythmia.</p> <p>b. Due to (or as a consequence of): Coronary artery disease.</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier 		29c. License number D0021730		29d. Date signed (Month, Day, Year) Sept 23 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ KHAN MD. Sinai Hospital. Baltimore MD					
31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature 			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

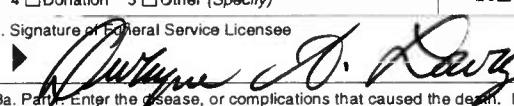
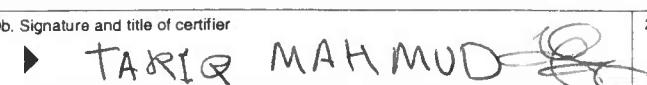
State of Maryland / Department of Health and Mental Hygiene

2006 30630

## Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SHIRLEY A. JONES</b>							2. Date of Death Month Day Year <b>September 24 2006</b>	3. Time of Death <b>10:12 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>SAINT AGNES HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>215-28-6078</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months	II Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>02/20/1932</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>BALTIMORE</b> 10c. City, Town or Location <b>CATONSVILLE</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>514 CROSBY ROAD</b>			10f. Zip Code <b>21228</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: <b>BLACK</b>			14. Race - American Indian, Black, White, etc.	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> 12TH			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> 2 YEARS <b>NURSE</b>			16b. Kind of Business/Industry <b>MEDICAL</b>		
	17. Father's Name (First, Middle, Last) <b>AUTHUR LAKE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>OLIDIA ROBINSON</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>CYNTHIA JONES / DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3805 ELMLEY AVE., BALTIMORE, MD 21213</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>KING MEM. PARK</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEM. PARK</b>			Date <b>9/30/06</b>	20c. Location - City or Town, State <b>WINDSOR MILL, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Septic shock</b> Approximate Interval Between Onset and Death <b>One week</b>								
	23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>								
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier  <b>TARIQ MAHMUD</b> 29c. License number <b>P20283</b> 29d. Date signed (Month, Day, Year) <b>September 24 2006</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TARIQ MAHMUD 900 CATON AVE BALTIMORE MD 21229</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>	32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

JONES, SHIRLEY A  
Division of Vital Records, P.O. Box 68760,   
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30631  
1- For State Amend item#19b, per FH, G859, 9/27/06 TT Certificate of Death Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leon Jackson</b>				2. Date of Death Month Day Year <b>September 20 2006</b>				3. Time of Death <b>7:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>50 Hoyle Lane</b>				4b. City, Town, or Location of Death <b>Severna Park</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>218-28-2313</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>74 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>May 11 1932</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent 10a. State <b>Maryland</b>				10c. City, Town or Location <b>Severna Park</b>				10d. Inside City Limits 1 Yes 2 No	
To Be Completed by Funeral Director	10e. Street and Number <b>50 Hoyle Lane</b>				10f. Zip Code <b>21146</b>				10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1953-54</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:					14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>0</b>	16b. Kind of Business/Industry <b>United States Naval Academy</b>							
	17. Father's Name (First, Middle, Last) <b>Solomon Jackson</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Mary E. White</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Janise Jackson (Daughter)</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>214 Parker Ave Annapolis, Md. 21401</b>								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Larry G. Green 100483</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veteran</b>	Date <b>9-26-06</b>	20c. Location - City or Town, State <b>Crownsville, Md.</b>						
	21. Signature of Funeral Service Licensee <b>Larry G. Green 100483</b>	22. Name and Address of Facility <b>Wm. Reese &amp; Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401</b>								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. <b>HYPERTENSION</b> Due to (or as a consequence of):</p> <p>b. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):</p> <p>c. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):</p> <p>d. _____</p>									
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	27. Manner of death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29d. Date signed (Month, Day, Year) <b>09/25/2006</b>				
	29b. Signature and title of certifier <b>STEPHEN R. GREEN</b>	29c. License number <b>025782</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEPHEN R. GREEN, 7575 RITCHIE HIGHWAY, GLEN BURNIE, MARYLAND 21060</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>	32. Registrar's Signature <b>Stephen R. Green</b>								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30632  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Marie Kaline</b>						2. Date of Death Month Day Year <b>September 20, 2006</b>	3. Time of Death <b>10:05A M</b>			
	4a. Facility Name (If not institution, give street and number) <b>5516 Patrick Henry Drive</b>			4b. City, Town, or Location of Death <b>Brooklyn Park</b>			4c. County of Death <b>Anne Arundel</b>				
Funeral Director	5. Social Security Number <b>216-20-3077</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>March 11, 1927</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Brooklyn Park</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>5516 Patrick Henry Drive</b>			10f. Zip Code <b>21225</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Clerk</b>		16b. Kind of Business/Industry <b>State of Maryland</b>						
	17. Father's Name (First, Middle, Last) <b>John Meyers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Watts</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. William F. Kaline, Jr.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Son 417 Fairfax Ave. Brooklyn Park, MD 21225</b>		Date <b>9/23/2006</b>				20c. Location - City or Town, State <b>Glen Burnie, MD</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Mad A. Varela NO 1357</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park</b>								
	21. Signature of Funeral Service Licensee <b>► Mad A. Varela NO 1357</b>		22. Name and Address of Facility <b>Singleton Funeral Home, P.A. 1 Second Ave SW, Glen Burnie, MD 21061</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<b>De hospitale Lung Cancer</b>						Approximate Interval Between Onset and Death <b>0WKS</b>		
	{		a. Due to (or as a consequence of):								
	{		b. Due to (or as a consequence of):								
	{		c. Due to (or as a consequence of):								
	{		d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier <b>► Mrs. B. Varela</b>		29c. License number <b>031158</b>						29d. Date signed (Month, Day, Year) <b>September 21, 2006</b>		
	30. Name and address of person who completed cause-of-death (Item 23a) (Type, Print) <b>Kussell Q. Delaney 305 Hoechst Dr., Glen Burnie, MD 21061</b>										
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>Anna B. Varela</b>								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, X

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

06-07146

Roxanne Lopez

UNK UNK

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No.

2006 30633

## 1. For State Registrar

**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

Roxanne Lopez

2. Date of Death

Month

Day

Year

September 22, 2006

3. Time of Death

0750 hrs

**Funeral  
Director**

4a. Facility Name (if not institution, give street and number)

7700 Penn Belt Drive

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Prince George's

5. Social Security Number

058-78-0854

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

16

Yrs.

If Under 1 Year

If Under 24 Hrs

8. Date of Birth (MM/DD/YYYY)

Months

Days

Hours

Min.

07/12/1990

9. Birthplace (State or Foreign Country)

Ny

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10e. Street and Number

140 Glendale St.

10f. Zip Code

33804

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No specify Puerto Rican Hispanic

14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired)

Student

16b. Kind of Business/Industry

Grade School

17. Father's Name (First, Middle, Last)

Amador Lopez

18 Mother's Name (First, Middle, Maiden Surname)

Sonia Mendez

19a. Informant's Name/Relationship (Type, Print)

Sonia Mendez Mother

19b. Mailing Address (Street and Number or Rural Route Number, City, Town, State, Zip Code)

140 Glendale St. Lakeland MD 213804

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Hill Burial Park

Date

10/02/2006

Lakeland Fl

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Wesley Chavis III Funeral Service  
10684 Southern MD BLVD Dunkirk MD 20754

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Sharp Force Injuries

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?

1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient2  ER/Outpatient3  DOA

Other

4  Nursing Home5  Residence6  Other Scene

27. Manner of Death

1  Natural5  Pending Investigation2  Accident6  Could not be determined3  Suicide4  Homicide

28a. Date of Injury (Month, Day, Year)

FOUND: Sep 22, 2006

28b. Time of Injury

FOUND: 0745 hrs

28c. Injury at Work?

1  Yes 2  No

28d. Describe how injury occurred

Subject was stabbed and cut

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Parking Lot

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7700 Penn Belt Drive, Forrestville, MD

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
(Check only one)2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 23, 2006

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

SEP 27 2006

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006

30634

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>MARY REGINA LASEK</b>						2. Date of Death Month Day Year <b>September 18 2006</b>	3. Time of Death <b>8:43 A M</b>
4a. Facility Name (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>						4b. City, Town, or Location of Death <b>FREDERICK</b>	4c. County of Death <b>FREDERICK</b>
5. Social Security Number <b>201-20-5288</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88 Yrs.</b>	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 17, 1918</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>

Funeral Director

Usual Residence of Decedent  
10a. State  
**Virginia** 10b. County  
**Loudon** 10c. City, Town or Location  
**Lovettsville**  
10d. Inside City Limits  
 Yes  No

To Be Completed by Funeral Director

11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>7</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Research Glassware Technician</b>	16b. Kind of Business/Industry <b>Pittsburgh Medical Labs</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Smaglo</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Amelia Hyrkiel</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Cynthia Lasek Davis, Daughter</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 178, Waterford, Virginia 20197</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>M01113</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary Mausoleum</b>	Date <b>09/21/2006</b>	20c. Location - City or Town, State <b>Pittsburgh, PA</b>
21. Signature of Funeral Service Licensee <b>TCH</b>	22. Name and Address of Facility <b>John N. Elachko Funeral Home</b>		
	3447 Dawson Street, Pittsburgh, PA 15213		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Congestive heart failure</b>						Approximate Interval Between Onset and Death <b>1 day</b>	
<p>a. Due to (or as a consequence of): <b>Congestive heart failure</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Urinary Tract infection.</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Oupatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29c. License number <b>D51643</b>	29d. Date signed (Month, Day, Year) <b>9-18-06</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>65 c Thomas Thomson Dr Frederick MD 21712</b>							
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>						32. Registrar's Signature <b>Rosemary J. Hayes</b>	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

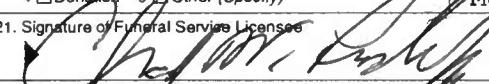
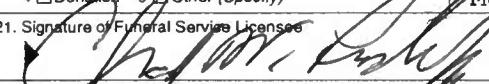
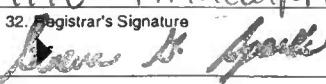
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30635

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lucille P. Lowery</b>						2. Date of Death Month Day Year <b>Sept. 20 2006</b>	3. Time of Death M <b>10:55 a.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>1500 Pattison Road</b>			4b. City, Town, or Location of Death <b>Essex</b>			4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>212-28-0790</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89 Yrs.</b>	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 23, 1917</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>			
	Usual Residence of Decedent 10a. State <b>Maryland</b>			10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>1500 Pattison Road</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>12 Years</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify:		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Benjamin H. McDaniel</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hattie L. Estes</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Emma Jean Smith (Daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1500 Pattison Road Essex, Maryland 21221</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Park Cem.</b>			Date <b>9/25/2006</b>	20c. Location - City or Town, State <b>Dorsey, MD</b>		
	21. Signature of Funeral Service Licensed 			22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cerebrovascular occlusion</b>								Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Renal failure</b>									
	a. Due to (or as a consequence of): <b>Cerebrovascular occlusion</b>									
	b. Due to (or as a consequence of): <b>Renal failure</b>									
	c. Due to (or as a consequence of):									
	d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 		29c. License number <b>D18598</b>						29d. Date signed (Month, Day, Year) <b>9/21/06</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sheldon Muner 9110 Philadelphia Rd Balto. MD 21237</b>									
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 2006

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

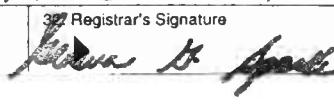
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30636

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SAMUEL E. LITTLE JR.</b>							2. Date of Death Month Day Year <b>SEPTEMBER 24 2006</b>	3. Time of Death 6:17 PM	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL</b>			4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>			4c. County of Death <b>BALTIMORE</b>			
Funeral Director	5. Social Security Number <b>217-12-3954</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>04/29/1924</b>	9. Birthplace (State or Foreign Country) <b>N. CAROLINA</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>BALTIMORE CITY</b>									10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>3659 GLENGYLE AVE, UNIT 1A</b>			10f. Zip Code <b>21215</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>ARMY</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10TH</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LONGSHOREMAN</b>			16b. Kind of Business/Industry <b>STEAMSHIP TRADERS</b>			
	17. Father's Name (First, Middle, Last) <b>SAMUEL E. LITTLE, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LATHA WINFIELD</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>ELIZABETH H. LITTLE / WIFE</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3659 GLENGYLE AV, UNIT 1A, BALTIMORE, MD 21215</b>				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NEW CATHEDRAL CEM</b>			Date <b>9/28/06</b>	20c. Location - City or Town, State <b>BALTIMORE, MD</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>MYOCARDIAL INFARCTION</b>								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <b>MYOCARDIAL INFARCTION</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ABDOMINAL AORTIC ANEURYSM</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> DECLINED		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D54352</b>							
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 24 2006</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MIRCEA TODOR, MD 5401 OLD COURTH RD.</b>								RANDALLSTOWN, MD 21133	
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30637

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be advised at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		STEPHEN LANASA JR.				2. Date of Death Month Day Year SEPTEMBER 23, 2006 625PM	3. Time of Death 625PM
4a. Facility Name (If not institution, give street and number)		Future Care Chesapeake				4b. City, Town, or Location of Death Arnold	
4c. County of Death Anne Arundel		4d. Usual Residence of Decedent		10a. State MD		10b. County Anne Arundel	10c. City, Town or Location Glen Burnie
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1907 Ridgewick Road		10f. Zip Code 21061		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: white		14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Self Employed		16b. Kind of Business/Industry Self Employed			
17. Father's Name (First, Middle, Last) Stephen A. Lanasa, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Rosina Sansone					
19a. Informant's Name/Relationship (Type, Print) Mrs. Lillian M. Lanasa / wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1907 Ridgewick Road; Glen Burnie, MD 21061		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		Date 09/27/2006	20c. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee ► DOROTHY WALTERS MO1364		22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
a. Due to (or as a consequence of): <b>ASPIRATION PNEUMONIA</b>		3 HOURS					
b. Due to (or as a consequence of): <b>ADVANCED DEMENTIA</b>		10 YEARS					
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier ► Michael A. Jackson MD		29c. License number D46360		29d. Date signed (Month, Day, Year) September 25, 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL A. JACKSON MD 8601 Veterans Highway, Millersville, MD		31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature Debbie B. Gandy			

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30538

1- For State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <i>Jacqueline mack</i>				2. Date of Death Month Day Year September 23, 2006		3. Time of Death 1505 hrs	
Funeral Director		4a. Facility Name (if not institution, give street and number) Bon Secours Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death NIA	
		5. Social Security Number <i>217-84-3897</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>41</i>	If Under 1 Year Months Days Hours Min. Yrs.	8. Date of Birth (MM/DD/YYYY) <i>07-21-1965</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
		Usual Residence of Decedent 10a. State <i>Md.</i>		10b. County <i>NIA</i>	10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number <i>2110 Westwood Ave</i>			10f. Zip Code <i>21217</i>		10g. Citizen of What Country? <i>USA</i>		
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>12th</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:			14. Race - American Indian, Black, White, etc. <i>Black</i>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Supervisor</i>			16b. Kind of Business/Industry <i>Phyllis Food Production</i>		
		17. Father's Name (First, Middle, Last) <i>Donald mack</i>		18 Mother's Name (First, Middle, Maiden Surname) <i>Odeella Taylor</i>					
		19a. Informant's Name/Relationship (Type, Print) <i>Jacqueline mack - daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2110 westwood ave Baeto, md. 21217</i>					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Trinity Cemetery</i>	Date <i>9-29-06</i>	20c. Location - City or Town, State <i>Dundalk, md.</i>				
		21. Signature of Funeral Service Licensee <i>Jacqueline mack</i>		22. Name and Address of Facility <i>270 Fred Harrison Pass Gary P. March Funeral Home Baeto, md. 21229</i>					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Hypertensive cardiovascular disease</i>							
		Due to (or as a consequence of): a. <i>Hypertensive cardiovascular disease</i>							
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. Due to (or as a consequence of):							
		<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	#23a, 27, per ME, g860, 10/25/06 TT					
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown							
		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth      2 <input type="checkbox"/> Fetal death      3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death      5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown							
		23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No      24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:							
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide      4 <input type="checkbox"/> Homicide							
		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and title of certifier <i>Theodore M. King, Jr., MD.</i>							
		29c. License number <i>O.C.M.E.</i>							
		29d. Date signed (Month, Day, Year) <i>September 25, 2006</i>							
		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
		31. Date filed (Month, Day, Year) <i>SEP 27 2006</i>							
		32. Registrar's Signature <i>Laura S. Jones</i>							

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

2006 30639

## 1. For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Neil Mullikin</b>					2. Date of Death Month Day Year August 30, 2006	3. Time of Death 1110 hrs			
Funeral Director	4a. Facility Name (if not institution, give street and number) <b>75 Hampton Park Boulevard #104</b>			4b. City, Town, or Location of Death <b>Capitol Heights</b>		4c. County of Death <b>Prince George's</b>				
To Be Completed by Funeral Director	5. Social Security Number <b>219-36-9940</b>		6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>69 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>July 21, 1937</b>	9. Birthplace (State or Foreign Country) <b>Washington DC</b>			
Physician/ Medical Examiner	10a. State <b>MD</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Capitol Heights</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	10e. Street and Number <b>75 Hampton Park Boulevard #104</b>			10f. Zip Code <b>20743</b>		10g. Citizen of What Country? <b>United States</b>				
Physician/ Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Career Navy</b>			16b. Kind of Business/Industry <b>Military</b>			
Physician/ Medical Examiner	17. Father's Name (First, Middle, Last) <b>Theodore Elridge Mullikin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Elderdice Gordy</b>					
Physician/ Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Gumer, Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>279 Buggy Whip Drive kyle, Texas 78640</b>						
Physician/ Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify <b>M01113</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>			Date <b>09/23/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic cardiovascular disease</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____								Approximate Interval Between Onset and Death	
Physician/ Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Physician/ Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  _____								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
Physician/ Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene							
Physician/ Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
Physician/ Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Physician/ Medical Examiner	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated				29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>August 31, 2006</b>	
Physician/ Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) <b>Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>			32. Registrar's Signature <b>Pamela B. Southall</b>						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30640

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Earl William Mathews</b>				2. Date of Death Month Day Year <b>September 21, 2006</b>	3. Time of Death M <b>9:40 P M</b>		
	4a. Facility Name (If not institution, give street and number) <b>406 Regina Drive</b>		4b. City, Town, or Location of Death <b>Edgewood</b>		4c. County of Death <b>Harford</b>			
Funeral Director	5. Social Security Number <b>141-24-3601</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <b>Mar. 21, 1930</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
	Usual Residence of Decedent <b>Maryland Harford</b>		10c. City, Town or Location <b>Edgewood</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>406 Regina Drive</b>			10f. Zip Code <b>21040</b>	10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Specialist 5</b>		16b. Kind of Business/Industry <b>US Government</b>			
	17. Father's Name (First, Middle, Last) <b>William (nmn) Mathews</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Sadie (nmn) Merrill</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Karolina Talbert / Granddaughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>803 Philadelphia Road, Joppa, MD 21085</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Charles Engel</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>9-23-06</b>	20c. Location - City or Town, State <b>Towson, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Charles Engel</b>		22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 						Approximate Interval Between Onset and Death <b>hours</b>	
	<p>a. Due to (or as a consequence of): <b>Pulmonary Aspiration</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia COPD</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			<b>M</b>					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29b. Signature and title of certifier <b>Craig M. Shaughnessy MD</b>		29c. License number <b>D0037028</b>		29d. Date signed (Month, Day, Year) <b>September 22, 2006</b>			
	30. Name and address of person who completed cause of death (Type, Print) <b>CRAIG SHAUGHNESSY MD</b>							
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>Craig M. Shaughnessy</b>					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

MASKELL / Gerald  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, W.F.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

1/20 AM  
1/20  
9/24/06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30641  
Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner

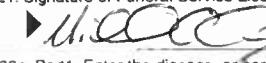
Funeral Director

To Be Completed by Funeral Director

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Gerald Francis Maskell		September 24, 2006				11:20aM	
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death				Reg. No.	
Oak Crest Care Center		Parkville					
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) April 10, 1917	9. Birthplace (State or Foreign Country) Arkansas
432-12-3854							
Usual Residence of Decedent							
10a. State Maryland	10b. County Baltimore Co.	10c. City, Town or Location Parkville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8800 Walter Blvd. Apt. 4209		10f. Zip Code 21234				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Elevator Repairman		General	
17. Father's Name (First, Middle, Last) Patrick Francis Maskell				18. Mother's Name (First, Middle, Maiden Surname) Lucille Hightower			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carol A. Huesman / Daughter 7006 Carmae Road Sykesville, Maryland 21784					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Mem. Park		Date	20c. Location - City or Town, State Sept. 27, 2005 Baltimore, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Michael E. Canapp Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause. Enter disease or injury that initiated events resulting in death) Last							
<p>a. <u>pneumonia</u> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>cerebral vascular infarction with hemorrhage</u>							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
				M			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 158646					
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) September 25, 2006					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Monica 8800 Walter Boulevard Parkville, MD 21234							
31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30642  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death
OLGA NORWOOD		SEPTEMBER 22, 2006				2:00 A. M.
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death
FOREST HILL HEALTH & REHAB CENTER		FOREST HILL				HARFORD
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Nov. 23, 1912	9. Birthplace (State or Foreign Country) Chicago, Ill.
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State Maryland	10b. County Harford	10c. City, Town or Location Belair				
10e. Street and Number 801 Coconut Ct. Apt. E			10f. Zip Code 21014			10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Homemaker			16b. Kind of Business/Industry Homemaking - Own Home	
17. Father's Name (First, Middle, Last) Rudolph Wall			18. Mother's Name (First, Middle, Maiden Surname) Bertha Gertz			
19a. Informant's Name/Relationship (Type, Print) Edward J. Norwood, Jr. (Son)						
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1402 Purdue Ct. Belair, Md. 21014						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery	Date 9-26-2006			20c. Location - City or Town, State Baltimore, Md.	
21. Signature of Funeral Service Licensee ► E. J. Lassahn			22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						
<p>a. <i>Cerebral vascular accident</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>						
Approximate Interval Between Onset and Death						
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____						
23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier ► David S. Dunn						
29c. License number D32299						
29d. Date signed (Month, Day, Year) September 22, 2006						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD. 21014						
31. Date filed (Month, Day, Year) SEP 27 2006						
32. Registrar's Signature John S. Dunn						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30643

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

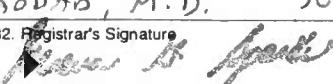
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year SEPTEMBER 23 2006				3. Time of Death 6:50 PM	
MARTIN G-WYN NEFF							
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death	
HARBOR HOSPITAL							
5. Social Security Number 312-56-8796		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 18, 1950	9. Birthplace (State or Foreign Country) Indiana
Usual Residence of Decedent		10c. City, Town or Location Essex				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State Maryland		10b. County Baltimore					
10e. Street and Number 802 Platinum Avenue		10f. Zip Code 21221				10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Salesman			
17. Father's Name (First, Middle, Last) Gwynn Neff				18. Mother's Name (First, Middle, Maiden Surname) Margaret Langhirt			
19a. Informant's Name/Relationship (Type, Print) Carol L. Simonette ex-wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 Platinum Avenue, Essex, Maryland 21221					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date September 26, 2006	20c. Location - City or Town, State Baltimore City, MD.		
21. Signature of Funeral Service Licensee Anthony C. Connelly		22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death) PNEUMONIA							
Approximate Interval Between Onset and Death >5 years							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
{ b. Due to (or as a consequence of): NON-SMALL CELL LUNG CANCER							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Human Immunodeficiency virus							
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number RES 001				29d. Date signed (Month, Day, Year) 9/23/2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARIS JADIN HADAD, M.D. 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225							
31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend Item 1 per doc 20c per ft g859 9-27-06 vt  
 State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Certificate of Death

Reg. No.

2006 30644

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Ruth Brenner Newman</b> <b>RUTH BRENNER NEUMAN</b>				2. Date of Death Month Day Year <b>SEPT. 24, 2006</b>	3. Time of Death <b>12:30 A M</b>			
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>5462 DELPHINIUM COURT</b>			4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>220-48-3748</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <b>05/03/1948</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>HOWARD</b> 10c. City, Town or Location <b>COLUMBIA</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number <b>5462 DELPHINIUM COURT</b>			10f. Zip Code <b>21045</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STUDENT ASSISTANT</b>		16b. Kind of Business/Industry <b>HOWARD COUNTY SCHOOL SYSTEM</b>					
		17. Father's Name (First, Middle, Last) <b>MORTON ALBERT</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>BRENNER BETTIE</b>		19. Informant's Name/Relationship (Type, Print) <b>STUART NEWMAN / HUSBAND</b>					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW CONG</b>		Date <b>09/26/2006</b>	20c. Location - City or Town, State <b>Baltimore REISTERSTOWN, MD</b>				
		21. Signature of Funeral Service Licensee <b>► Matt Cen</b>	22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death		
		<p>a. Due to (or as a consequence of): <b>Respiratory Failure</b></p> <p>b. Due to (or as a consequence of): <b>Amyotrophic Lateral Sclerosis</b></p> <p>c. Due to (or as a consequence of):  </p> <p>d. Due to (or as a consequence of):  </p>								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <b>D0038291</b>						29d. Date signed (Month, Day, Year) <b>Sept 25, 2006</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeffrey D. Rothstein, Johns Hopkins University, 600 N. Wolfe, Baltimore MD</b>								
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>	32. Registrar's Signature <b>► Jeffrey D. Rothstein</b>						ORIGINAL	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

# 1 of 202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b, 12, 15, 18, per FH, C860, 10/20/06, WS  
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30645  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
	James C. O'Day				Sept. 24, 2006	7:15 A M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death
	303 Woodlawn Drive			Forest Hill		Harford
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 16, 1918	9. Birthplace (State or Foreign Country) Pennsylvania
070-22-8707						
Usual Residence of Decedent						
10a. State New York	10b. County Tioga Broome	10c. City, Town or Location Owego				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 85 Cafferty Hill Road			10f. Zip Code 13760			10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry Assembly Computer Manufacturer		
17. Father's Name (First, Middle, Last) James C. O'Day				18. Mother's Name (First, Middle, Maiden Surname) Julia F. (unk) Donovan		
19a. Informant's Name/Relationship (Type, Print) Richard Camden				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Woodlawn Dr., Forest Hill, Maryland 21050		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Russell Sliz		20b. Place of Disposition (Name of cemetery, crematory or other place) Calvary Cemetery		Date 9-29-06	20c. Location - City or Town, State Johnson City, NY	
21. Signature of Funeral Service Licensee Russell Sliz						
22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Approximate Interval Between Onset and Death years						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
<p>a. Due to (or as a consequence of): Coronary Artery Disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Julie Tunny mo		29c. License number D53186			29d. Date signed (Month, Day, Year) September 25, 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julie Tunny mo 605 W. McPhail rd Bel Air MD 21014						
31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature Julie Tunny				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30646  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH YVONNE PLANK</b>							2. Date of Death Month Day Year <b>SEPTEMBER 21 2006</b>	3. Time of Death <b>7:15 P M</b>
	4a. Facility Name (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>FREDERICK</b>			4c. County of Death <b>FREDERICK</b>		
Funeral Director	5. Social Security Number <b>448-32-9731</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Jan. 14, 1938</b>	9. Birthplace (State or Foreign Country) <b>Oklahoma</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Frederick</b> 10c. City, Town or Location <b>Frederick</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>730 Carroll Parkway Apt. 6C</b>			10f. Zip Code <b>21701</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>4 X</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify:	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retail Clerk</b>			16b. Kind of Business/Industry <b>Department Store</b>		
	17. Father's Name (First, Middle, Last) <b>Elijah Bascom Thompson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Odessa Hobson</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Jackie Lynn Campbell (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6616 Commodore Ct., New Market, MD 21774</b>						
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Dennis Pittman</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Provence Cemetery</b>			Date <b>9/30/06</b>	20c. Location - City or Town, State <b>Ardmore, OK</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service License <b>Dennis Pittman</b>		22. Name and Address of Facility <b>Harvey Douglas Funeral Home 122 1st Ave. S.W. Ardmore, OK 73401</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>3 d</b> <b>2 d</b> <b>6 weeks</b> <b>2 mo</b>
	<p>a. <b>Leukopenic sepsis</b> Due to (or as a consequence of):</p> <p>b. <b>Pancytopenia</b> Due to (or as a consequence of):</p> <p>c. <b>Chemo - radiation</b> Due to (or as a consequence of):</p> <p>d. <b>Anal carcinoma</b></p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypo thyroidism</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29b. Signature and title of certifier <b>Dennis Pittman</b>		29c. License number <b>0146 26</b>			29d. Date signed (Month, Day, Year) <b>Sept 22, 2006</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PG Murphy 501 W 700 St Frederick MD 21701</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>James B. Pittman</b>						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30647

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than 'natural', or items 23a or 28-a show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
<b>MAE POSEY</b>		<b>SEPTEMBER 22, 2006</b>				8:15 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
<b>BALTIMORE WASHINGTON MEDICAL CENTER</b>		<b>GLEN BURNIE</b>				<b>ANN ARUNDEL</b>	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)			
214.01.3426		<input type="checkbox"/> XX	88	SEPT 25, 1917			
9. Birthplace (State or Foreign Country)		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No XX					
MD							
Usual Residence of Decedent							
10a. State MD	10b. County ANNE ARUNDEL	10c. City, Town or Location MILLERSVILLE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No XX	
10e. Street and Number 132 DREXEL DR.			10f. Zip Code 21108			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give XX Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes XX <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) TRAINING INSTRUCTOR		16b. Kind of Business/Industry MANUFACTURING			
17. Father's Name (First, Middle, Last) GEORGE L. TARLTON				18. Mother's Name (First, Middle, Maiden Surname) BESSIE MAE VINCENT			
19a. Informant's Name/Relationship (Type, Print) CHARLES E. POSEY SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 DREXEL DR. MILLERSVILLE, MD 21108					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD NATIONAL MEMORIAL PARK		Date 9.27.2006	20c. Location - City or Town, State LAUREL, MD		
21. Signature of Funeral Service Licensee K GREGORY FINK		22. Name and Address of Facility FINK FUNERAL HOME, P.A. 426 CRAIN HWY S.W. GLEN BURNIE, MD 21061					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 3 WEEKS
<p>a. <b>SEPSIS</b> Due to (or as a consequence of):</p> <p>b. <b>CHOLECYSTITIS</b> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>							3 DAYS
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D0062714</b>					
29b. Signature and title of certifier <b>GUILLERMO JOSÉ GIANGRECO</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 22, 2006</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GUILLERMO JOSÉ GIANGRECO 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061</b>							
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <i>[Signature]</i>					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30648

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
--	------------------------------------	------------------

William Jefferson Foland

Sept. 25, 2006

10:49 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
--	--------------------------------------	---------------------

3823 E Baker Ave.

Abingdon

Harford

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
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218-18-8802

80

Aug. 17, 1926

Florida

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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Maryland Harford

Abingdon

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
------------------------	---------------	-------------------------------

3823 E. Baker Avenue

21009

USA

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
--	--	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civilian Personnel Officer	16b. Kind of Business/Industry U.S. Government
---	--	---

College (1-4 or 5+)

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
---	---

Paul Herman Foland

Bertha Mae Slough

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
--	---

Edith G. Foland/ Wife

3823 E. Baker Ave., Abingdon, Maryland 21009

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
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Hilltop Service Corp 9-27-06

Towson, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
---	----------------------------------

*Stephen A. Neugros*McComas Funeral Home, P. A.  
1317 Cokesbury Rd., Abingdon, Maryland 21009

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death 2 yrs.
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Immediate Cause (Final disease or condition resulting in death)	a. <i>METASTIC COLON CANCER</i> Due to (or as a consequence of):
---	---

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
--	-------------------------------------

	c. Due to (or as a consequence of):
--	-------------------------------------

	d. Due to (or as a consequence of):
--	-------------------------------------

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
---	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
--	---	---

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one)
---	-------------------------------------

Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
--	---

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
---	---	---------------------	--	-----------------------------------

	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--	--

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
--

29b. Signature and title of certifier <i>RONALD SUPE</i>	29c. License number D 33099	29d. Date signed (Month, Day, Year) 9/26/06
---	--------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
--

RONALD SUPE 155 West High Street, ELKTON, MD 21921
--

31. Date filed (Month, Day, Year) SEP 27 2006	32. Registrar's Signature <i>Debra A. Foland</i>
--	---

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg No.

2006 30649

1. For State Registrar

**Physician/  
Medical Examiner**

8/1/35		1. Decedent's Name (First, Middle, Last) <b>ANITA E. PHILLIPS</b>						2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> September 25, 2006		3. Time of Death 1151 hrs					
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Sinai Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>					
		5. Social Security Number <b>213 92 1648</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>43</b> Yrs.		If Under 1 Year Months <input type="text"/> Days <input type="text"/>		If Under 24Hrs Hours <input type="text"/> Min <input type="text"/>		8. Date of Birth (MM/DD/YYYY) <b>FEB. 27, 1963</b> MD.			
To Be Completed by Funeral Director		9. Birthplace (State or Foreign Country) <b>MD.</b>													
		10a. State <b>MD</b> 10b. County <b>N/A</b>						10c. City, Town or Location <b>BALTIMORE</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		10e. Street and Number <b>2732 RIGGS AVENUE</b>						10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>					
		11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>						12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> <small>If Yes, Give Year or Dates:</small>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> <small>specify:</small>				14. Race - American Indian, Black, White, etc. <b>Specify: BLACK</b>	
Baltimore, MD 21215-0036		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9TH</b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) <b>LAUNDRY</b>				16b. Kind of Business/Industry <b>NURSING HOME</b>			
		17. Father's Name (First, Middle, Last) <b>CHARLES PHILLIPS</b>						18 Mother's Name (First, Middle, Maiden Surname) <b>LILLIAN M. HILL</b>							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit		19a. Informant's Name/Relationship (Type, Print) <b>EARL RINGGOLD / SON</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2732 RIGGS AVE. BALTO, MD. 21216</b>							
		20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify</b>						20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TRINITY CEMETERY</b>		Date <b>SEPT. 30, 2006</b>		20c. Location - City or Town, State <b>BALTO, MD. 21213</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>Bernadine J. Scruggs</b>						22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD. 21213</b>							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypertensive heart disease</b> <small>Due to (or as a consequence of):</small>						Approximate Interval Between Onset and Death							
b. <small>Due to (or as a consequence of):</small>															
c. <small>Due to (or as a consequence of):</small>															
d. <small>Due to (or as a consequence of):</small>															
State Registrar		<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED		item#23a,27,perME,g860, 10/20/06 TT									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>		23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year		23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  _____  _____  _____						24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>					
		25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		26 Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other				27 Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> <b>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>							
State Registrar		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>(Specify)</b>				1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
State Registrar		29a. Certifier <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29b. Signature and title of certifier <b>Patricia Aronica-Pollak</b>						29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 26, 2006</b>					
State Registrar		30. Name and address of person who completed cause of death (Item 23a) <b>Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>						31. Date filed (Month, Day, Year) <b>SEP 27 2006</b> 32. Registrar's Signature <b>Leanne B. Pollak</b>							

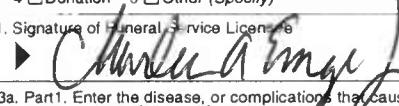
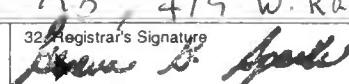
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30650

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death	
	Michael Frank Rudnicke							September 25, 2006			8:00 P M	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death				
	722 MacPhail Court N			Bel Air				Harford				
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Nov. 10, 1946	9. Birthplace (State or Foreign Country) Illinois		
	357-40-7337											
Usual Residence of Decedent												
10a. State Maryland	10b. County Harford	10c. City, Town or Location Bel Air							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 722 MacPhail Court N				10f. Zip Code 21014			10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5±			16b. Kind of Business/Industry Teacher			Public Education					
17. Father's Name (First, Middle, Last) Edmund Robert Rudnicke				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Beatta Kolar								
19a. Informant's Name/Relationship (Type, Print) Cheryl Rudnicke / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 722 MacPhail Court N, Bel Air, Maryland 21014								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Spring Hill Cemetery			Date 9-30-06			20c. Location - City or Town, State Danville, IL					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year N/A			Approximate Interval Between Onset and Death 7 Years		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>Myocardial Infarction</i> Due to (or as a consequence of):	b. <i>Coronary Artery Disease</i> Due to (or as a consequence of):	c. <i>Hypertension</i> Due to (or as a consequence of):	d.								
IF FEMALE: <input type="checkbox"/> N/A	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year N/A			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred N/A					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A	28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier 	29c. License number D 380 86			29d. Date signed (Month, Day, Year) 9-26-06								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wallace Johnson 722 419 W. Ribwood St., Suite 620												
31. Date filed (Month, Day, Year) SEP 27 2006	32. Registrar's Signature 											

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland

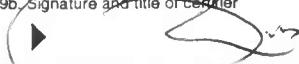
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend #7 Per FH G859 9/28/06 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

2006 30651

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katherine Rawlings							2. Date of Death Month 09 Day 20 Year 2006	3. Time of Death 10:00p M
	4a. Facility Name (If not institution, give street and number) 3306 Greenmeade Road			4b. City, Town, or Location of Death Windsor Mill			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 228-14-2389	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 9, 1919	9. Birthplace (State or Foreign Country) VA		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Windsor Mill 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
	10e. Street and Number 3306 Greenmeade Road			10f. Zip Code 21244			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: African-American	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Senior Assistant Helper		16b. Kind of Business/Industry Baltimore City				
	17. Father's Name (First, Middle, Last) Chester A. Lundy				18. Mother's Name (First, Middle, Maiden Surname) Salley Mae Wadler				
	19a. Informant's Name/Relationship (Type, Print) Suzanne M. Dorsey/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3306 Greenmeade Rd., Windsor Mill, MD 21244				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Mortal <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Ceme.			Date 9-25-06	20c. Location - City or Town, State Glen Burnie, MD		
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 								
	22. Name and Address of Facility Wylie F/H P.A. of Falto. Co. 9200 Liberty Rd., Randallstown, MD 21133								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dehydration								
	Approximate Interval Between Onset and Death days								
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying Cause (Disease or injury that initiated events resulting in death) Recurrent rectal carcinoma								
	months								
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier  Attending								
	29c. License number D17118								
	29d. Date signed (Month, Day, Year) Sept 25, 2006								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Schwartz M.D. 3512 Newland Road 21218								
State Registrar	31. Date filed (Month, Day, Year) SEP 27 2006								
	32. Registrar's Signature 								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30652

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Darryl A. Rose</b>				2. Date of Death Month Day Year <b>SEPTEMBER 22, 2006</b>	3. Time of Death <b>2:20 PM</b>					
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>						
Funeral Director	5. Social Security Number <b>212-44-8102</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58 Yrs.</b>	If Under 1 Year Months Days Hours Min. <b></b>	8. Date of Birth (Month, Day, Year) <b>2-14-48</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>NA</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number <b>436 N. Luzerne Avenue</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b></b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>							
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>	16b. Kind of Business/Industry <b>NA</b>							
	17. Father's Name (First, Middle, Last) <b>Lawrence Burns</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Margurite Jackson</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Travonda Webster Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>436 N. Luzerne Ave., Baltimore, Md. 21224</b>								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b></b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk.</b>	Date <b>9-30-06</b>	20c. Location - City or Town, State <b>Arbutus, Md.</b>						
	21. Signature of Funeral Service Licensee <b>Joseph R. Walters Jr.</b>		22. Name and Address of Facility <b>March F.H. East 1101 E. North Ave., Baltimore, Md. 21202</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>NON SMALL CELL LUNG CANCER 2 YEARS</b>						Approximate Interval Between Onset and Death				
	<p>a. Due to (or as a consequence of): <b>NON SMALL CELL LUNG CANCER 2 YEARS</b></p> <p>b. Due to (or as a consequence of): <b></b></p> <p>c. Due to (or as a consequence of): <b></b></p> <p>d. Due to (or as a consequence of): <b></b></p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9 Unknown</b>			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b></b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b></b>			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b></b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29d. Date signed (Month, Day, Year) <b>SEPTEMBER 22, 2006</b>				
	29b. Signature and title of certifier <b>JOSEPH PUTTHUMANA MD</b>						29c. License number <b>D47A23</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSEPH PUTTHUMANA 201 E. UNIV. PKWY, BALTIMORE MD 21218</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>Burns &amp; [Signature]</b>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30653  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Anthony Regin</i>							2. Date of Death Month 09 Day 24 Year 06 0909AM	3. Time of Death
	4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Center			4b. City, Town, or Location of Death Glen Burnie			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number <i>220-82-7429</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Apr 21, 1961	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Pasadena							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 760 202 22nd Street			10f. Zip Code 21122			10g. Citizen of What Country? United States		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Cashier			16b. Kind of Business/Industry Food		
	17. Father's Name (First, Middle, Last) Melvin Regin				18. Mother's Name (First, Middle, Maiden Surname) Theresa White				
	19a. Informant's Name/Relationship (Type, Print) Theresa Regin / Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5959 Fairington Road Lithonia, Georgia 30038				
Physician / Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bestgate Memorial Park			Date Sep 29 2006	20c. Location - City or Town, State Annapolis, MD	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Melvin Regin</i>				22. Name and Address of Facility Miller's Metropolitan Chapel 1922 Forest Drive Annapolis, MD				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>Acute Myocardial Infarction</i></p> <p>b. Due to (or as a consequence of): <i>Cardio myo Pathy</i></p> <p>c. Due to (or as a consequence of): <i>Hypertensive cardiovascular disease</i></p> <p>d.</p>								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year	
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>1. Pulmonary fibrosis</i> <i>2. Substance Abuse - Cocaine</i>							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>30009453</i>						
	29b. Signature and title of certifier <i>Carol A. Phillips</i>		29d. Date signed (Month, Day, Year) <i>9/25/06</i>						
	30. Name and address of person who completed cause of death (Item 23a) <i>Carol A. Phillips</i>		31. Date filed (Month, Day, Year) <i>SEP 27 2006</i>						
	32. Registrar's Signature <i>Carol A. Phillips</i>		33. Print <i>Carol A. Phillips</i>						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or if Item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Anthony Regin**  
Baltimore, Maryland 21215-0036

06-0913

Jayden Deon Riggsbee

## Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg No

2006 30654

1. For State  
RegistrarPhysician/  
Medical Examiner  
JAYDEN DEON RIGGSBEE2. Date of Death  
Month Day Year  
September 13, 20063. Time of Death  
0631 hrsFuneral  
Director

4a. Facility Name (if not institution, give street and number) Holy Cross Hospital						4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
5. Social Security Number 212-77-5047		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 20		If Under 1 Year Months 20	If Under 24 Hrs. Hours 20	8. Date of Birth (MM/DD/YYYY) 8-23-2006	9. Birthplace (State or Foreign Country) MARYLAND	

8/3/06  
Baltimore, MD 21215-0036  
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRINGS		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2314 GEORGIAN WOODS PLACE				10f. Zip Code 20902		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -0-		College (1-4 or 5+) -0-		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) infant		16b. Kind of Business/Industry infant	
17. Father's Name (First, Middle, Last) ANTONIO RIGGSBEE				18. Mother's Name (First, Middle, Maiden Surname) KRISTIS BROWN			
19a. Informant's Name/Relationship (Type, Print) KRISTIS BROWN (MOTHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2314 GEORGIAN WOODS PLACE SILVER SPRING, MD 20902			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) STARK WALTON CEMETERY		Date 9-17-2006	20c. Location - City or Town, State KELTOR, NC		
21. Signature of Funeral Service Licensee JONATHAN D. HIBNER GILLIAM FUNERAL HOME 706 GHENT ST. WINDSOR, NORTH CAROLINA 27983							

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. Sudden unexplained death in infancy Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____		Approximate Interval Between Onset and Death				
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other.						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Fnd 9/13/2006	28b. Time of Injury Fnd 5:47 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown			
		28e. Place of Injury - At home, farm, street, factory, office building, etc (Specify) found at residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2314 Georgian Woods Place Silver Spring, MD				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Ling Li, MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) September 14, 2006				
30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature John J. Spaulding						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2006 30655

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

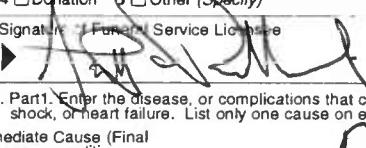
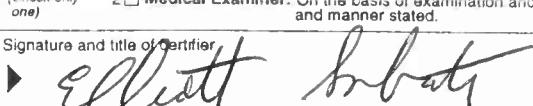
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit source.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
ISABELLE J. SCHLACHTA		SEPTEMBER 26, 2006				1:50 P.M.	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
CRANBERRY COTTAGES ASSISTED LIVING		ARNOLD				ANNE ARUNDEL	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) NOV. 22, 1909	9. Birthplace (State or Foreign Country) ITALY
186-10-2650		96					
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location ARNOLD					
10e. Street and Number 186 CAMPUS GREEN DRIVE		10f. Zip Code 21012				10g. Citizen of What Country? UNITED STATES	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
17. Father's Name (First, Middle, Last) MATTHEW ALBERTELLI		18. Mother's Name (First, Middle, Maiden Surname) MARIA UNKNOWN					
19a. Informant's Name/Relationship (Type, Print) BETTY MC ILVAINE / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 BOWLINE ROAD SEVERNA PARK, MD 21146					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORIAL, INC.		Date SEPT. 27, 2006	20c. Location - City or Town, State CATONSVILLE, MARYLAND		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY. S.E. GLEN BURNIE;MD 21061					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Dementia</i>				Approximate Interval Between Onset and Death 5 years	
Sequentially list conditions, 1st, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):					
23d. Date of delivery Month Day Year							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>LIVING</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number D20094		29d. Date signed (Month, Day, Year) SEPT. 27, 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELLIOTT GORBATY, M.D., 1411 MADISON PARK DR., GLEN BURNIE, MD 21061							
31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature 					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30656

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death
<i>Carolyn L. Smith</i>	Sept	23	2006	10:03A M	

4a. Facility Name (If not institution, give street and number)

*SINAI HOSPITAL OF BALTIMORE*

4b. City, Town, or Location of Death

*BALTIMORE CITY*

4c. County of Death

Funeral  
Director

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11-25-1929	9. Birthplace (State or Foreign Country) <i>Baltimore, MD</i>
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Usual Residence of Decedent

10a. State <i>MD</i>	10b. County	10c. City, Town or Location <i>Baltimore</i>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number <i>3612 Rosedale Road</i>	10f. Zip Code <i>21215</i>	10g. Citizen of What Country? <i>USA</i>
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11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1948</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>
--	---	--	---

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Nurses Aid</i>	16b. Kind of Business/Industry <i>Nursing Home</i>
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17. Father's Name (First, Middle, Last) <i>Raymond Matthews</i>	18. Mother's Name (First, Middle, Maiden Surname) <i>Cornelia Brown</i>
--	--

19a. Infant's Name/Relationship (Type, Print) <i>Wendell R. Smith / Son</i>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6625 Brighton Ave., Baltimore, MD 21215</i>
--	---

20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garrison Forest Cemetery</i>	Date <i>Oct. 2, 2006</i>	20c. Location - City or Town, State <i>Owings Mills, MD</i>
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21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>	22. Name and Address of Facility <i>Vaughn C. Greene Funeral Services 8728 Liberty Rd., Randallstown, MD 21133</i>
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. <i>SEVERE METABOLIC ACIDOSIS</i> Due to (or as a consequence of):	<i>10 days</i>
b. <i>LIVER FAILURE</i> Due to (or as a consequence of):	<i>10 days</i>
c. <i>RENAL FAILURE</i> Due to (or as a consequence of):	<i>10 days</i>
d.	

IF FEMALE:	23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)	23d. Date of delivery Month Day Year
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23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
---	--

24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
---	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <i>1</i> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	26. Place of Death (Check only one) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
---	--	--

27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29d. Date signed (Month, Day, Year)
--	-------------------------------------

29b. Signature and title of certifier <i>Aruna Rokkam</i>	29c. License number <i>RES 000</i>
--	---------------------------------------

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ARUNA ROKKAM, MD Sinai Hospital of Baltimore</i>	31. Date filed (Month, Day, Year) <i>SEP 27 2006</i>	32. Registrar's Signature <i>Aruna Rokkam</i>
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State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death006 30657  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANBER GUMERCINDO JUAREZ SANCHEZ</b>							2. Date of Death Month Day Year <b>January 7, 2006</b>			3. Time of Death <b>9:43 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Woods near Mission Rd @ Concord Road</b>			4b. City, Town, or Location of Death <b>Jessup</b>			4c. County of Death <b>Howard</b>					
Funeral Director	5. Social Security Number <b>NONE</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>19 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>11/27/1986</b>	9. Birthplace (State or Foreign Country) <b>GUATEMALA</b>					
	Usual Residence of Decedent 10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>11502 Lockwood Drive # D2</b>			10f. Zip Code <b>20904</b>			10g. Citizen of What Country? <b>Guatemala</b>					
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>XXXX</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Guatemalan</b>			14. Race - American Indian, Black, White, etc. <b>Hispanic</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>			16b. Kind of Business/Industry <b>Construction, Co.</b>					
17. Father's Name (First, Middle, Last) <b>Cirilo Pedro Juarez Sanchez</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marcela Sanchez Lopez</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Isaias Sanchez Lopez (uncle)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1614 Neely Rd Silver Spring, MD 20903</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Randolph B. Morris</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Concepcion Cemetery Chihuahua</b>			Date <b>10/29/06</b>	20c. Location - City or Town, State <b>Dpto. Quezaltenango, Guatemala.</b>				
21. Signature of Funeral Service Licensee <b>Randolph B. Morris</b>				22. Name and Address of Facility <b>Santa Cruz Funerales Latinos, INC. 600 Kennedy ST, N.W. Washington D.C. 20011</b>								

Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): <b>Blunt and Sharp Force Injuries</b>							Approximate Interval Between Onset and Death	
		b. Due to (or as a consequence of):								
		c. Due to (or as a consequence of):								
		d. _____								
IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>			23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year) <b>Found 11/7/06</b>		28b. Time of Injury <b>9:35 AM</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Subject assaulted</b>				
29a. Certifier (Check only one) <b>Medical Examiner</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>woods</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Mission Rd @ Concord Rd Jessup MD</b>					
29b. Signature and title of certifier <b>Carol Hallan</b>		29c. License number <b>OCME</b>			29d. Date signed (Month, Day, Year) <b>January 8, 2006</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Carol Hallan</b>		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>			32. Registrar's Signature <b>John R. Brooks</b>					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30658

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Herbert Moore Shamblin</b>			2. Date of Death Month Day Year <b>September 23<sup>rd</sup> 2006</b>	3. Time of Death <b>2:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Baltimore Washington Medical Center</b>			4b. City, Town, or Location of Death <b>Glen Burnie</b>	4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>214-54-5057</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>Aug. 6, 1954</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Glen Burnie</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>845 Brighton Place</b>			10f. Zip Code <b>21061</b>	10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanical Engineer</b>		16b. Kind of Business/Industry <b>Plumbing / Heating</b>	
	17. Father's Name (First, Middle, Last) <b>Hoyt Shamblin</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Long</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Deborah Ann Shamblin/Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>845 Brighton Place Glen Burnie MD 21061</b>		
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Chesapeake Cremation</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Cremation</b>	Date <b>Sept. 26, 2006</b>	20c. Location - City or Town, State <b>Stevensville, MD</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Mark A. Kourou M01357</i>	22. Name and Address of Facility <b>Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Acute myocardial infarction</b>					Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of): <b>Diabetes Mellitus</b>					
	c. Due to (or as a consequence of):					
	d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier <i>K. Ambalavaner</i>					29c. License number <b>D 51596</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K. Ambalavaner, 7845 Oakwood Road, 103, Glen Burnie, MD 21061</b>					29d. Date signed (Month, Day, Year) <b>September 23<sup>rd</sup> 2006</b>
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>	32. Registrar's Signature <i>John B. Apolis</i>	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30659

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALFRED H. SCHWARTZMAN</b>				2. Date of Death Month Day Year <b>SEPT. 24, 2006</b>	3. Time of Death <b>6:33 P M</b>				
	4a. Facility Name (If not institution, give street and number) <b>27 CHASEMOUNT COURT</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>					
Funeral Director	5. Social Security Number <b>216-28-0441</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month Day Year) <b>08/09/1933</b>	9. Birthplace (State or Foreign Country) <b>NC</b>				
	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>X</b>			
To Be Completed by Funeral Director	10e. Street and Number <b>27 CHASEMOUNT COURT</b>			10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>KOREA</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4</b>	16b. Kind of Business/Industry <b>PHARMACY</b>							
	17. Father's Name (First, Middle, Last) <b>MURRAY</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>SCHWARTZMAN MARION CAPLAN</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>BENITA SCHWARTZMAN / WIFE</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>27 CHASEMOUNT COURT - BALTIMORE, MD 21209</b>								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>CHIZUK AMUNO ARLINGTON 9/26/2006</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE, MD</b>	Date <b>9/26/2006</b>	20c. Location - City or Town, State						
	21. Signature of Funeral Service Licensee <b>Scott M. Cuttler</b>	22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>pneumonia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>pneumonia</b> Due to (or as a consequence of):  b. <b>metastatic esophageal cancer</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.						Approximate Interval Between Onset and Death <b>1 week</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						28a. Date of Injury (Month, Day Year) <b>M</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier <b>L. Austin Dayle</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29c. License number <b>023809</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>L. Austin Dayle mo, Greenbaum Cancer Ctr, 22 S. Greene St., Baltimore MD 21201</b>						29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>			
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>John B. Miller</b>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

mark. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30660

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 11:05 AM
John Martin Tipton Jr.	September 21, 2006	

Funeral  
Director

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Center	Bel Air	Harford

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Maryland	Harford	Jarrettsville	

10e. Street and Number

3808 Jarrettsville Pike	10f. Zip Code 21084	10g. Citizen of What Country? USA
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11. Marital Status

1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12	College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supervisor	16b. Kind of Business/Industry County Government
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17. Father's Name (First, Middle, Last)

John Martin Tipton Sr.	18. Mother's Name (First, Middle, Maiden Surname) Nellie Mae Hess
------------------------	--

19a. Informant's Name/Relationship (Type, Print)

Anna S. Tipton/ Wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3808 Jarrettsville Pike, Jarrettsville, Maryland
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20a. Method of Disposition

1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Jarrettsville Cem	Date 9-25-06	20c. Location - City or Town, State Jarrettsville, Maryland
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21. Signature of Funeral Service Licensee

	22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death 20 minutes
---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of): <i>Ventricular Arrhythmia</i>	b. Due to (or as a consequence of): <i>Renal Failure</i>	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
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IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
---	--	--

25. Was case referred to medical examiner?

1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death

1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

	29c. License number D0063337	29d. Date signed (Month, Day, Year) 9/21/06
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian G LaRocco, MD 500 Upper Chesapeake Drive, Bel Air, MD 21084

31. Date filed (Month, Day, Year)

SEP 27 2006

32. Registrar's Signature



ORIGINAL

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

TIPTON, JOHN

Division of Vital Records, P.O. Box 68760, ✓

Within 24 hours after death  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30661

For  
State  
Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Hattye Watson</b>								2. Date of Death Month Sept Day 23 Year 2006		3. Time of Death 1:02 A M			
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>Joseph Ritchie Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>					
		5. Social Security Number <b>253-42-2445</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		If Under 1 Year Months		If Under 24 Hrs. Hours		8. Date of Birth (Month, Day, Year) <b>Dec. 1, 1888</b>		9. Birthplace (State or Foreign Country) <b>Georgia</b>	
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
		10e. Street and Number <b>3800 W. Belvedere Ave.</b>				10f. Zip Code <b>21215</b>				10g. Citizen of What Country? <b>USA</b>					
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>nurse</b>				16b. Kind of Business/Industry <b>Hospitals</b>					
		17. Father's Name (First, Middle, Last) <b>Samuel Beard</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Mae Thompson</b>									
		19a. Informant's Name/Relationship (Type, Print) <b>Jamlyn Butler - daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4244 Parkside Drive Baeto, md, 21206</b>									
		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Metro Crematory</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>926-06 Catonsville, md.</b>				Date <b>9/26/06</b>					
		21. Signature of Funeral Service Licensee <b>Gary J. March</b>				22. Name and Address Facility <b>330 Frederick Pass Gary J. March Funeral Home Baeto, md, 21229</b>									
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>years</b>					
		a. <b>metastatic cancer, probable breast primary</b> Due to (or as a consequence of):				b. Due to (or as a consequence of):				c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):													
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9/26/06</b>				23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>											
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
		29b. Signature and title of certifier <b>ETSO MD</b>								29c. License number <b>D24170</b>		29d. Date signed (Month, Day, Year) <b>Sept. 23, 2006</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ETSO MD Ritchie Hospice 838 N Eutaw St Baltimore MD 21201</b>								31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>					
		32. Registrar's Signature <b>[Signature]</b>													

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

102 AM

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Hattye Watson 9/23/06

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30662  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Marion Williams</i>							2. Date of Death Month <b>9</b> Day <b>23</b> Year <b>2006</b>	3. Time of Death <b>0945 AM</b>
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Med Cntr</i>			4b. City, Town, or Location of Death <i>Baltimore</i>				4d. County of Death <i>NA</i>	
Funeral Director	5. Social Security Number <b>579-62-0921</b>			6. Sex <b>XXM</b>	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>7-25-46</b>	9. Birthplace (State or Foreign Country) <b>S.C.</b>
Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>P.G.</b> 10c. City, Town or Location <b>District Hgts.</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
10e. Street and Number <b>3502 Keystone Manor Place</b>					10f. Zip Code <b>20747</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>3/66 3/68</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Grocery Clerk</b>				16b. Kind of Business/Industry <b>Giant Food</b>
17. Father's Name (First, Middle, Last) <b>Unknown</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie M. Jones</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Earthalee Williams/Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3502 Keystone Manor Pl. District Hgts. Md. 20747</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverdale Park</b>			Date <b>9/30/06</b>	20c. Location - City or Town, State <b>Riverdale, Md.</b>		
21. Signature of Funeral Service Licensee <i>James E. Williams</i>					22. Name and Address of Facility <b>The House of Williams Fun. Svc. 814- Upshur Street, N.W.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
<p>a. <i>Traumatic Brain Injury with Subdural Hematoma</i> Due to (or as a consequence of):</p> <p>b. <i>Abdominal Sepsis</i> Due to (or as a consequence of):</p> <p>c. <i>Multigile organ Failure</i> Due to (or as a consequence of):</p> <p>d. _____</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <b>7-31-2006</b>		28b. Time of Injury <b>11:13 PM</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <i>MC &amp; Soni truck I 495 and Route 295</i>		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>						
29b. Signature and title of certifier <i>Leonard Burton</i>			29c. License number <b>P17377</b>			29d. Date signed (Month, Day, Year) <b>9-23-06</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Leonard Burton UMMC</b>									
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>			32. Registrar's Signature <i>Leon B. Beck</i>						

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

q+1

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30663

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

		1. Decedent's Name (First, Middle, Last) <b>JOHN WASHINGTON</b>						2. Date of Death Month <b>9</b> Day <b>24</b> Year <b>06</b>		3. Time of Death <b>8:20 AM</b>	
		4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>N/A</b>			
Funeral Director		5. Social Security Number <b>213 34 7027</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>DEC. 6, 1938</b>	9. Birthplace (State or Foreign Country) <b>S. CAROLINA</b>			
To Be Completed by Funeral Director		10a. State <b>MD</b>		10b. County <b>N/a</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number <b>1305 E. LAFAYETTE AVE</b>			10f. Zip Code <b>21213</b>			10g. Citizen of What Country? <b>USA</b>			
Physician /Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>22</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>BLACK</b>			14. Race - American Indian, Black, White, etc. <b>BLACK</b>		
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12TH</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STEEL WORKER</b>			16b. Kind of Business/Industry <b>BETHLEHEM STEEL CO.</b>				
		17. Father's Name (First, Middle, Last) <b>PENNER WASHINGTON</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ELLEN HALL</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>EMMALEE HALL / sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1305 E. LAFAYETTE AVENUE BALTO, MD. 21213</b>			Date		20c. Location - City or Town, State		
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>ABRUTUS MEM. PK</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ABRUTUS MEM. PK</b>			20c. Location - City or Town, State <b>SEPT. 29, 2006 BALTO, MD.</b>				
		21. Signature of Funeral Service Licensee <b>Bernadine Scruggs</b>		22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</b>							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ASPIRATION PNEUMONIA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>SEPTICEMIA</b>						Approximate Interval Between Onset and Death			
		a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. _____									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>END STAGE RENAL DISEASE</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier <b>MD (RESIDENT)</b>		29c. License number <b>000 RES</b>			29d. Date signed (Month, Day, Year) <b>9/25/06</b>				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SANDEEP MAJGUN, 5601 LOCUS RAUBN BLVD, BALTIMORE, MD - 21239</b>									
		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>[Signature]</b>							

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial-transit slip.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30664

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>POLINA ZAKHAROV</b>							2. Date of Death Month Sep Day 24 Year 2006	3. Time of Death 9:36 PM
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital of Baltimore</b>			4b. City, Town, or Location of Death <b>Baltimore City</b>			4c. County of Death N/A		
Funeral Director	5. Social Security Number <b>214-94-2512</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day Year) <b>02/18/1930</b>	9. Birthplace (State or Foreign Country) <b>UKRAINE</b>		
	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>					
10e. Street and Number <b>2 LONG STREAM COURT #201</b>				10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ACCOUNTANT</b>			16b. Kind of Business/Industry <b>ACCOUNTING</b>				
17. Father's Name (First, Middle, Last) <b>GREGORY SHRUBSTOK</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HANNA BURSTEIN</b>					
19a. Informant's Name/Relationship (Type, Print) <b>ELEANOR TOWNSHEND / DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>222 SACRED HEART LANE - REISTERSTOWN, MD 21136</b>			Date <b>9/26/2006</b>			20c. Location - City or Town, State <b>OWINGS MILLS, MD</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HAR SINAI CEMETERY</b>							
21. Signature of Funeral Service Licensee <b>Scott M. Cutler</b>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. <b>Pneumonia.</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>1 month.</b>	
b. <b>Pancreatic Cancer</b> Due to (or as a consequence of):								<b>4 yrs.</b>	
c. Due to (or as a consequence of):									
d. <b>Acute renal failure</b> <b>Arthritis.</b>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute renal failure</b> <b>Arthritis.</b>					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Anand Singla, MD</b>		29c. License number <b>RBS - 000</b>			29d. Date signed (Month, Day, Year) <b>Sept 24th 2006</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anand Singla, MD, Sinai Hosp. of Baltimore</b>									
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>Janet B. Fletcher</b>							

06-07131

Donna Christine Brown

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No. 2006 30665

1- For State  
Registrar**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director**

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 2 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 58760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician  
/Medical  
Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last) <b>Donna Christine Brown</b>		2. Date of Death Month Day Year <b>September 21, 2006</b>		3. Time of Death <b>1153 hrs</b>	
4a. Facility Name (if not institution, give street and number) <b>859 Principio Road</b>		4b. City, Town, or Location of Death <b>Port Deposit</b>		4c. County of Death <b>Cecil</b>	
5. Social Security Number <b>212-86-8318</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b>	If Under 1 Year Months Days Hours Min. Yrs	
				8. Date of Birth (MM/DD/YYYY) <b>Aug. 15, 1969</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
10a. State <b>MD</b>		10b. County <b>Harford</b>	10c. City, Town or Location <b>Churchville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>21 Calvary Road</b>			10f. Zip Code <b>21028</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>0</b>		16b. Kind of Business/Industry <b>Daycare provider</b> <b>Day Care</b>	
17. Father's Name (First, Middle, Last) <b>Clyde Franklin Brown</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Karen Marie Donn</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Rose Brown (Sister)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>908 Monica Circle Kingsville, MD 21087</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <b>J. Bell II</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Angel Hill Cemetery</b>		Date <b>9/26/06</b>	20c. Location - City or Town, State <b>Havre de Grace, MD</b>
21. Signature of Funeral Service Licensee <b>J. Bell II</b>		22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>			

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		a. Complications of morbid obesity Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death	
<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth      2 <input type="checkbox"/> Fetal death      3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death      5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I  <b>Crohn's disease; diabetes mellitus; uterine carcinoma</b>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA      Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier  (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29b. Signature and title of certifier  <b>Ana Rubio MD. Assistant Medical Examiner</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 22, 2006</b>	
30. Name and address of person who completed cause of death (Item 23a)  <b>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>							
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>Laura A. Smith</b>					

**State  
Registrar**

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30666  
Reg. No.

For  
State  
Registrar

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Adelfa Guillermina Balea</b>							2. Date of Death Month Day Year <b>September 9, 2006</b>	3. Time of Death a.m. <b>5:01</b>
	4a. Facility Name (If not institution, give street and number) <b>623 Ridge Road</b>			4b. City, Town, or Location of Death <b>Salisbury</b>			4c. County of Death <b>Wicomico</b>		
<b>Funeral Director</b>	5. Social Security Number <b>212-66-1670</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>6/25/1925</b>	9. Birthplace (State or Foreign Country) <b>Cuba</b>
<b>To Be Completed by Funeral Director</b>	Usual Residence of Decedent								
	10a. State <b>Maryland</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Salisbury</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>623 Ridge Road</b>			10f. Zip Code <b>21801</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>			16b. Kind of Business/Industry <b>Education</b>		
	17. Father's Name (First, Middle, Last) <b>Jose Serra</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Amelia Hernandez</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Antonio O. Balea/son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4314 Stirbridge Dr., Salisbury, MD 21804</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wicomico Memorial Park</b>			Date <b>9/14/06</b>	20c. Location - City or Town, State <b>Salisbury, MD</b>		
	21. Signature of Funeral Service Licensee <b>David H. Thompson CFSP</b>								
	22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>								
<b>Physician /Medical Examiner</b>	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Immediate Cause (Final disease or condition resulting in death)								
	23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. <b>END STAGE LIVER FAILURE</b> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____								
	23d. Date of delivery Month Day Year								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	24. Did case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined								
	27. Date of Injury (Month, Day, Year) <input type="checkbox"/> Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	28. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								
	29c. License number <b>DOO57333</b>								
	29d. Date signed (Month, Day, Year) <b>9/12/06</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>813 B Eastern Shore Dr, Salisbury, MD 21804 (P.T. Menya, MD)</b>								
	31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>								
	32. Registrar's Signature 								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at \_\_\_\_\_.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30667

Certificate of Death

Reg. No.

1- For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Mary Margaret Bailey

2. Date of Death

Month Day Year  
September 13, 2006

3. Time of Death

8:19 A M

Physician  
/Medical  
Examiner

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Carroll Hospital Center

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

220-18-7032

6. Sex

M  F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 12, 1925

9. Birthplace (State or Foreign Country)

Pittsburgh, PA

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

Yes  No

10e. Street and Number

102 Timber Ridge Drive, Apt# 210

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
 Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Mozetta Helen Campbell

19a. Informant's Name/Relationship (Type, Print)

John W. Bailey/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

409 Farm Creek Rd., Westminster, MD 21157

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

09/18/2006

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

412 Washington Rd., Westminster, P.A. MD, 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

congestive heart failure

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

Chronic obstructive lung disease

years

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes  No

9  Unknown

23c. If yes, outcome of pregnancy

Live birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (specify)

9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes  No  Probably  Unknown

25. Was case referred to medical examiner?

Yes  No

26. Place of Death (Check only one)

Hospital:  Inpatient  ER/Outpatient  DOA Other:

4  Nursing Home  Residence  Other (Specify)

27. Manner of Death

Natural

Accident

Suicide

Homicide

Pending investigation

Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

Yes  No

28d. Describe how injury occurred

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D23443

29d. Date signed (Month, Day, Year)

9-14-06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAYAN VAWALA MD 1130 Backmore Blvd Westminster MD 21157

31. Date filed (Month, Day, Year)

SEP 14 2006

32. Registrar's Signature

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

2006 30668

## 1- For State Registrar

Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Daniel Wade Carpenter</b>				2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> September 17, 2006	3. Time of Death 1205 hrs	
	4a. Facility Name (if not institution, give street and number) <b>Maryland General Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>	4c. County of Death	
Funeral Director  <b>To Be Completed by Funeral Director</b>	5. Social Security Number <b>225-35-5768</b>	6. Sex <b>1 X M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>22 Yrs</b>	If Under 1 Year  Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (MM/DD/YYYY) <b>Oct. 4, 1983</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent  10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Millersville</b>				10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 X No</b>		
Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	10e. Street and Number <b>600 Millright Court #43</b>			10f. Zip Code <b>21108</b>	10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <b>1 X Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>2002-04</b></b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 X No specify: white</b>	14. Race - American Indian, Black, White, etc <b>white</b>	
Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 2 College (1-4 or 5+)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HVAC installer</b>	16b. Kind of Business/Industry <b>HVAC</b>		
	17. Father's Name (First, Middle, Last) <b>Pat W. Carpenter, father</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Deborah Kay Mayhugh 20714 7006 Boston Ave., Rose Haven, MD</b>			
Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>Pat W. Carpenter, father</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7006 Boston Ave., Rose Haven, MD 20714</b>			
	20a. Method of Disposition <b>1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>	Date <b>09/22/2006</b>	20c. Location - City or Town, State <b>Crownsville, MD</b>	
Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Service Licensee <b>Ranya E Hubbell</b>			22. Name and Address of Facility <b>Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Methadone intoxication</b>			Approximate Interval Between Onset and Death			
Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	b.  Due to (or as a consequence of):						
	c.  Due to (or as a consequence of):						
Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	d.  <b>X UNPENDED X AMENDED item#17,18 perFH, 23a,27,28a-f,perME,g859,9/28/06 TT</b>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>	23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year		
Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>		
					24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other</b>				
	27. Manner of Death <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at Work? 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day, Year) <b>unk</b>	28b. Time of Injury <b>unk</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 X No</b>	28d. Describe how injury occurred <b>unk</b>	
Physician/ Medical Examiner  <b>To Be Completed by Physician/Medical Examiner</b>	28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>(Specify) unk</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>unk</b>		
	29a. Certifier (Check only one) <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated</b>				29c. License number <b>O.C.M.E.</b>		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) <b>Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>				29d. Date signed (Month, Day, Year) <b>September 18, 2006</b>		
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>				Registrar's Signature <b>Leanne A. Hallan</b>		

06-07190

Carlos Manuel Davila

1- For State Registrar

Physician/  
Medical Examiner

Funeral Director

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

completely filled in by the funeral director, page 2 should be detached for use as the burial transit

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30559

2. Date of Death  
Month Day Year  
September 23, 20063. Time of Death  
1914 hrs

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>CARLOS Manuel DAVILA</b>						2. Date of Death Month Day Year September 23, 2006		3. Time of Death 1914 hrs	
Funeral Director		4a. Facility Name (if not institution, give street and number) 30500 Pine Knoll Drive						4b. City, Town, or Location of Death Princess Anne		4c. County of Death Somerset	
To Be Completed by Funeral Director		5. Social Security Number <b>583-39-4955</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>30</b> Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (MM/DD/YYYY) <b>06-01-1976</b>	
										9. Birthplace (State or Foreign Country) <b>Puerto Rico</b>	
		10a. State <b>Md</b>		10b. County <b>Somerset</b>		10c. City, Town or Location <b>Princess ANNE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number <b>30500 PINE KNOLL DRIVE</b>				10f. Zip Code <b>21853</b>				10g. Citizen of What Country? <b>U. S. A.</b>	
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		14. Race - American Indian, Black, White, etc. Specify: <b>Hispanic</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Disabled - none</b>		16b. Kind of Business/Industry <b>NONE - disabled</b>					
		17. Father's Name (First, Middle, Last) <b>Gilberto</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Davila Evelyn Mendoza</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>SUZANN DAVILA (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30500 pine knoll dr. Princess Anne, md 21853</b>							
Physician / Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify <b>Meadow Bridge Cem</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadow Bridge Cem</b>		Date <b>9-28-06</b>	20c. Location - City or Town, State <b>Eden, md</b>				
		21. Signature of Funeral Service Licensee <b>M. Lescalle</b>		22. Name and Address of Facility <b>Bennie Smith FUNERAL HOME</b>		23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <b>Seizure disorder</b> Due to (or as a consequence of): b. <b>Head injuries</b> Due to (or as a consequence of): c. <b></b> Due to (or as a consequence of): d. <b></b>		Approximate Interval Between Onset and Death			
		<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED #23a-b, PII, 27, 28a-f, perME, g862, 12/8/06 TT							
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>cocaine use</b>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>1/27/1996</b>	28b. Time of Injury <b>12:36 am</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>passenger in a motor vehicle accident</b>				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>road</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Rt. 13 South of Eden Allen Rd. Eden, MD</b>					
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 24, 2006</b>			
		30. Name and address of person who completed cause of death (Item 23a) <b>Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>									
		31. Date filed (Month, Day, Year) <b>SEP 25 2006</b>		32. Registrar's Signature <b>James H. Grable</b>							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30670  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Edith C. Daniels</i>							2. Date of Death Month Day Year <b>September 10, 2006 1:55 AM</b>	3. Time of Death
	4a. Facility Name (If not institution, give street and number) <b>1967 Fairfax Road</b>			4b. City, Town, or Location of Death <b>Annapolis</b>			4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>220-16-8326</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>92 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>9/2/1914</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>1967 Fairfax Road</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) <b>College (1-4 or 5+) 5+</b>		16b. Kind of Business/Industry <b>Teacher</b>			Education	
	17. Father's Name (First, Middle, Last) <b>William T. Crouse</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Hopf</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Alfred Daniels/son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1967 Fairfax Road Annapolis, Maryland 21401</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>MD Veterans Cemetery</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>		Date <b>9/15/2006</b>	20c. Location - City or Town, State <b>Crownsville, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>Ford E. Liles</i>		22. Name and Address of Facility John M. Taylor Funeral Home <b>147 Duke of Gloucester St., Annapolis, MD 21401</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>pneumonia</i>								Approximate Interval Between Onset and Death <b>2 weeks</b>
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>DIABETES HYPER TENSION DEMENTIA HYDROCEPHALUS</i>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DIABETES HYPER TENSION DEMENTIA HYDROCEPHALUS</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29b. Signature and title of certifier <i>S. Stephen J. Katz</i>		29c. License number <b>D38687</b>			29d. Date signed (Month, Day, Year) <b>9/11/2006</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEPHEN KATZ MD 31 Robinson Run, Severna Park, MD 21146</b>								
	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature <i>Karen A. Katz</i>						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

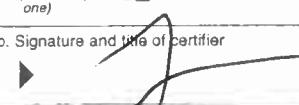
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30671  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>David Brooke Eckard</b>							2. Date of Death Month Day Year <b>September 13, 2006</b>	3. Time of Death <b>8:10 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>802 Mountain View Drive</b>			4b. City, Town, or Location of Death <b>Westminster</b>			4c. County of Death <b>Carroll</b>					
Funeral Director	5. Social Security Number <b>212-40-6035</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>July 1, 1944</b>	9. Birthplace (State or Foreign Country) <b>Baltimore, MD</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Carroll</b> 10c. City, Town or Location <b>Westminster</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
	10e. Street and Number <b>802 Mountain View Drive</b>			10f. Zip Code <b>21157</b>			10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Photographer</b>			16b. Kind of Business/Industry <b>U.S. Naval Academy</b>					
	17. Father's Name (First, Middle, Last) <b>Joseph Eckard</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Carolyn Crabbs</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Donna L. Eckard / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>802 Mountain View Drive, Westminster, MD 21157</b>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremations, Inc.</b>			Date <b>09/14/06</b>	20c. Location - City or Town, State <b>Hampstead, MD</b>				
	21. Signature of Funeral Service Licensee 											
	22. Name and Address of Facility <b>412 Washington Rd., Westminster, Pritts Funeral Home &amp; Chapel, P.A. MD 21157</b>											
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Non-Small Cell Lung Cancer</b>									Approximate Interval Between Onset and Death <b>14 months</b>		
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- Diabetes</b> <b>- Anemia.</b>											
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown											
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to compilation of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide					
	28a. Date of Injury (Month, Day, Year)			28b. Time of Injury			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>063031</b>			29d. Date signed (Month, Day, Year) <b>9/13/2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Yousuf Baffar MD 555 South Carter Street Westminster, MD 21157</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>			32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

16th CEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30672

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death			
EUGENE WILLIAM FAULKNER		SEPT. 19, 2006				7:50 A M			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death			
9819 SYLVAN TURN		NEWBURG				CHARLES			
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 66	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) JUNE 29, 1940	9. Birthplace (State or Foreign Country) WASH., DC		
10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location NEWBURG			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 9819 SYLVAN TURN		10f. Zip Code 20664				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER		16b. Kind of Business/Industry FAULKNER LIQUORS					
17. Father's Name (First, Middle, Last) EUGENE A. FAULKNER		18. Mother's Name (First, Middle, Maiden Surname) MARY ELIZABETH STEWART							
19a. Informant's Name/Relationship (Type, Print) J. CHRISTINE FAULKNER-SPOUSE P.O. BOX 357, NEWBURG, MARYLAND 20664		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERAN'S CEMET. 9-26-06 CHELTENHAM, MD		Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
a. Due to (or as a consequence of):  <i>Pancreatic Cancer</i>									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify) _____		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death Check only one			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one)		29b. Signature and title of certifier 							
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 52289							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nalin Mathur, MD. 11855 Holly Ln # 107, Waldorf, MD 20601		29d. Date signed (Month, Day, Year) 9/19/06							
31. Date filed (Month, Day, Year) SEP 27 2006		32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30673

Certificate of Death

Reg. No.

1 -  
For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

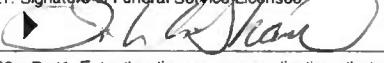
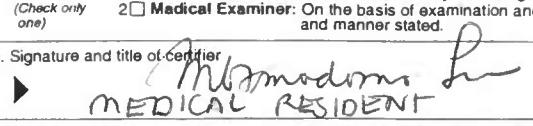
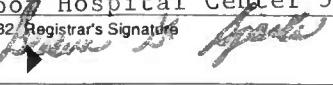
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>ELSIE IRVELINE HARGETT</b>		2. Date of Death Month <b>SEPTEMBER</b> Day <b>22</b> Year <b>2006</b>				3. Time of Death <b>7:03 A M</b>	
4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death	
5. Social Security Number <b>219-20-3756</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>73</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>8/14/1928</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>			
10e. Street and Number <b>1730 Pleasantville Drive Apt 1E</b>		10f. Zip Code <b>21061</b>				10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)      College (1-4 or 5+) 4			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
17. Father's Name (First, Middle, Last) <b>Irvin Franklin Hill Crouse</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>				16b. Kind of Business/Industry <b>Medical</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Sharan Lee Bidle Daughter</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Elizabeth Painter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1814 Aberdeen Circle Crofton, Maryland 21114</b>	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		Date <b>9/26/2006</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Keeney &amp; Basford P.A. F.H. M00176</b>				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
						Approximate Interval Between Onset and Death <b>ONE DAY</b>	
						Due to (or as a consequence of): <b>MULTI-ORGAN DYSFUNCTION</b>	
						Due to (or as a consequence of): <b>UROSEPSIS</b>	
						Due to (or as a consequence of): <b>CONGESTIVE HEART FAILURE</b>	
						Due to (or as a consequence of): <b>COAGULOPATHY</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  <b>MEDICAL RESIDENT</b>		29c. License number <b>RES 000</b>				29d. Date signed (Month, Day, Year) <b>SEPTEMBER 22, 2006</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
Motmadomo Lu The Harbor Hospital Center 3001 South Hanover Street Balto MD 21225							
31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend item #20b-c, per FH, G859, 9/27/06  
1- For State Registrar Certificate of Death Reg. No. 2006 30674

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eleanor Mae Howe</b>							2. Date of Death Month <b>September</b> Day <b>13</b> Year <b>2006</b>	3. Time of Death <b>9:21 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON COUNTY HOSPITAL</b>				4b. City, Town, or Location of Death <b>HAGERSTOWN</b>			4c. County of Death <b>WASHINGTON</b>	
Funeral Director	5. Social Security Number <b>289-22-8277</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>FEB. 13, 1926</b>	9. Birthplace (State or Foreign Country) <b>OHIO</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MARYLAND</b> 10b. County <b>WASHINGTON</b> 10c. City, Town or Location <b>BOONSBORO</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>19414 MANOR CHURCH ROAD</b>				10f. Zip Code <b>21713</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Year or Dates:</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>WHITE</b>				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>5+</b> <b>REGISTERED NURSE</b>	16b. Kind of Business/Industry <b>HOSPITAL</b>						
	17. Father's Name (First, Middle, Last) <b>PAUL WIESE</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>LILLIAN ZELLIN</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>CARL E. HOWE/SPOUSE</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19414 MANOR CHURCH ROAD, BOONSBORO, MARYLAND 21713</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Paul M. Dean</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Manor Church Cemetery</b>	Date <b>9/20/2006</b>	20c. Location - City or Town, State <b>Boonsboro, MD</b>					
	21. Signature of Funeral Service Licensee <b>Paul M. Dean</b>	22. Name and Address of Facility <b>BAST FUNERAL HOME</b>	22. Name and Address of Facility <b>7606 Old National Pike Boonsboro, Maryland 21713</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ACUTE HEMORRHAGIC STROKE</b>								Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b> a. <b>HYPERTENSIVE EMERGENCY</b> Due to (or as a consequence of): b. <b>HYPERTENSIVE EMERGENCY</b> Due to (or as a consequence of): c. <b>HYPERTENSIVE EMERGENCY</b> Due to (or as a consequence of): d. <b>HYPERTENSIVE EMERGENCY</b> Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, ATRIAL FIBRILLATION</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29d. Date signed (Month, Day, Year) <b>SEPTEMBER 13, 2006</b>							
	29b. Signature and title of certifier <b>► MADHAVI HUBBLY, MD</b>	29c. License number <b>D62562</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WASHINGTON COUNTY HOSPITAL 251 E ANTETAM STREET HAGERSTOWN MARYLAND 21740</b>								
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>	32. Registrar's Signature <b>► Madhavi Hubbly</b>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

20b-c  
129  
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30675

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
<b>Harrison Autumn Horton</b>		<b>September 18, 2006</b>		<b>2:50 P M</b>	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
<b>Charlotte Hall Veterans Home</b>		<b>Charlotte Hall</b>		<b>St. Mary's</b>	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>Dec. 3, 1933</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
Usual Residence of Decedent		10a. State <b>MD</b> 10b. County <b>St. Mary's</b> 10c. City, Town or Location <b>Charlotte Hall</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>29449 Charlotte Hall Road</b>		10f. Zip Code <b>20622</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 7</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Wood Processing Offbearer</b>		16b. Kind of Business/Industry <b>Saw Mill</b>	
17. Father's Name (First, Middle, Last) <b>Henry Harrison</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Otie Goad</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Marie Harrison / Sister-in-law</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21 Sparrow Road Duxbury, Virginia 24325</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>John B. Horton</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>		Date <b>September</b>	20c. Location - City or Town, State <b>Cheltenham, Maryland</b>
21. Signature of Funeral Service Licensee <b>John B. Horton</b>		22. Name and Address of Facility <b>Brinsfield-Echols Funl.Hme., P.A. M00641 30195 Three Notch Rd. Charlotte Hall, MD 20622</b>			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <b>Cardiac Arrhythmia</b> Due to (or as a consequence of):					
b. <b>Atherosclerotic Cardio Vascular Disease</b> Due to (or as a consequence of):					
c. <b>Hypertensive Heart Disease</b> Due to (or as a consequence of):					
d.					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
Old Cerebrovascular Accident		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vitamin B12 Deficiency					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D50653</b>			
29b. Signature and title of certifier <b>Gyan C. Surana</b>		29d. Date signed (Month, Day, Year) <b>9/20/06</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
Gyan C. Surana, M.D. 5851 Deale Churchton Road Deale, Maryland 20751					
31. Date filed (Month, Day, Year) <b>SEP 22 2006</b>		32. Registrar's Signature <b>James A. Jones</b>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30676

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23c or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

DD = 09/12/06  
e 0040

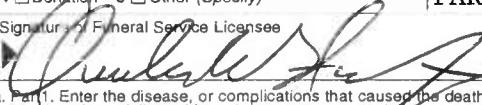
003 = 04/12/06  
10/10

McKenzie Hurst  
367-14-6517  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

		1. Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death	
		MARJORIE HURST			Month Day Year			Year	
		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
		ATLANTIC GENERAL HOSPITAL			BERLIN			WORCESTER	
5. Social Security Number		6. Sex		7. Age (In yrs. last birthday)		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
367-14-6517		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		96 Yrs.		Months	Days	Month Day Year	APRIL 28, 1910 ENGLAND
Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location			10d. Inside City Limits
		MARYLAND		WORCESTER		OCEAN PINES			1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?				
54 HATTERAS STREET		21811			ENGLAND				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 12		College (1-4 or 5+) SALES CLERK			RETAIL				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
CHARLES MARSH		SARAH SMITH							
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
JOAN M. WRIGHT/DAUGHTER		54 HATTERAS STREET, OCEAN PINES, MD 21811							
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		PARKLAWN MEM. PARK			9/15/06		ROCKVILLE, MARYLAND		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility							
		HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death)							24 hours		
a. <b>Sepsis</b> Due to (or as a consequence of):									
b. <b>Clostridium difficile colitis</b> Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fatal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number			29d. Date signed (Month, Day, Year)				
		D0056307			September 12, 2006				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
J. van Egmond MD, Atlantic General Hospital, 9733 Heathway Drive, Berlin, MD 21811									
31. Date filed (Month, Day, Year)		32. Registrar's Signature							
SEP 14 2006									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30677  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SAMUEL HODGE</b>				2. Date of Death Month <b>09</b> Day <b>10</b> Year <b>2006</b>	3. Time of Death <b>1417 M</b>
	4a. Facility Name (If not institution, give street and number) <b>Peninsula Regional Medical Center</b>				4b. City, Town, or Location of Death <b>Salisbury</b>	4c. County of Death <b>Wicomico</b>
Funeral Director	5. Social Security Number <b>075-56-3681</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48 Yrs.</b>	If Under 1 Year Months      Days      Hours      Min.	8. Date of Birth (Month, Day, Year) <b>04-07-1958</b>	9. Birthplace (State or Foreign Country) <b>South Carolina</b>
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Wicomico</b> 10c. City, Town or Location <b>Fruitland</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>200 NORTH Camden Ave</b>				10f. Zip Code <b>21826</b>	10g. Citizen of What Country? <b>U.S.A</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>12th</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>	16b. Kind of Business/Industry <b>Crisfield High School</b>			
	17. Father's Name (First, Middle, Last) <b>Sunny Abraham</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>QUEEN Hodge</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Dawn Hodge - Wife</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>200 N. Camden Ave Fruitland, MD 21826</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Salisbury Crematory</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>	Date <b>09-18-2006</b>	20c. Location - City or Town, State <b>Salisbury, MD</b>		
	21. Signature of Funeral Service Licensee <b>Anthony E. Ward Jr.</b>	22. Name and Address of Facility <b>Anthony E. Ward Funeral Home 30639 Hampden Ave. Princess Anne, MD 21853</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <b>&lt;72 hrs</b>	
	a. <b>Sepsis</b> Due to (or as a consequence of): <b>Hypotension</b> Due to (or as a consequence of): <b>metastatic adenocarcinoma</b> Due to (or as a consequence of):					
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>9</b>	23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HTN</b> <b>DM</b> <b>hyperlipidemia</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier <b>Dr. Clements</b>	29c. License number <b>HA061327</b>	29d. Date signed (Month, Day, Year) <b>9/10/06</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Clements</b> 100 Power St Salisbury MD 21804					
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>	32. Registrar's Signature <b>Debra A. Jones</b>				

**Please Type or Print in Black Indelible Ink**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg No.

2006 30678

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Edward Lee Iler</b>						2. Date of Death Month Day Year <b>September 9, 2006</b>		3. Time of Death <b>0412 hrs</b>		
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>Route 340 at the Potomac River Bridge</b>				4b. City, Town, or Location of Death <b>Knoxville</b>				4c. County of Death <b>Washington</b>		
To Be Completed by Funeral Director		5. Social Security Number <b>214-02-9819</b>		6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>35 Yrs.</b>		If Under 1 Year Months	If Under 24 Hrs Days	8. Date of Birth (MM/DD/YYYY) <b>June 5, 1971</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
		Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Brunswick</b>				10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 X <input checked="" type="checkbox"/> No</b>
		10e. Street and Number <b>530 Brunswick Street</b>						10f. Zip Code <b>21716</b>		10g. Citizen of What Country? <b>USA</b>		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4 or 5+) <b>Business Owner</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Owner</b>				16b. Kind of Business/Industry <b>Hauling/Demolition</b>		
		17. Father's Name (First, Middle, Last) <b>James William Iler</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Elizabeth Mallory</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>James W. Iler/father</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>402 Schley Avenue Frederick, MD 21702</b>								
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify <i>Beverly L. Heckrotte</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>09/12/06</b>		20c. Location - City or Town, State <b>Beltsville, MD</b>				
21. Signature of Funeral Service License <i>Beverly L. Heckrotte</i>		22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21020</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. Multiple Injuries Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Sep 9, 2006</b>		28b. Time of Injury <b>0330 hrs</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Pedestrian struck by auto</b>				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Major Road / Highway</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Route 340 East, Knoxville, MD</b>						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated						29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>September 9, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) <b>Mary G. Ripple MD. Deputy Chief Medical Examiner</b>												
31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>		32. Registrar's Signature <i>Mary G. Ripple</i>										
State Registrar												

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Injury or other traumatic event.** The Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30679

Reg. No.

1-  
For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ida Jones	September 17, 2006	3:40 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Nursing Center	Leonardtown	St. Mary's

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 28, 1919	9. Birthplace (State or Foreign Country) Virginia
230-03-1534					

Usual Residence of Decedent

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Maryland	St. Mary's	Lexington Park	

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
19141 Three Notch Road	20653	United States

11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home
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17. Father's Name (First, Middle, Last) Thomas Inge	18. Mother's Name (First, Middle, Maiden Surname) Hallie Bailey
--	--

19a. Informant's Name/Relationship (Type, Print) William J. Dixon / Son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 East Tantallon Drive, Ft. Washington, MD 20744-5217
--	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) First Missionary Bapt. 9-22-2006	Date	20c. Location - City or Town, State Lexington Park, MD
---	--	------	---

21. Signature of Funeral Service Licensee ► Kyle S. Simons	22. Name and Address of Facility Brinsfield Funeral Home, P.A. MO1206 22955 Hollywood Road, Leonardtown, MD 20650-0279
---	--

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death days wk yr
---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
--

a. Due to (or as a consequence of): Respiratory Failure
--

b. Due to (or as a consequence of): Metabolic Acidosis
---

c. Due to (or as a consequence of): Renal Failure
--

d. Due to (or as a consequence of): Generalized Atherosclerosis
--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
--	--

Dementia	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
----------	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	--------------------------	--	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D 06419	29d. Date signed (Month, Day, Year) 9-19-06
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30. Name and address of person who completed use of death (Item 23a) (Type, Print) James P. Jarboe, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636	32. Registrar's Signature James P. Jarboe
--	--

31. Date filed (Month, Day, Year) SEP 20 2006	33. Registrar's Signature James P. Jarboe
--	--

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Medical Certification: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2006 30680

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGINIA L. KINSEL</b>							2. Date of Death Month <b>SEPTEMBER</b> Day <b>7</b> Year <b>2006</b>	3. Time of Death <b>0830 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>FUTURECARE - CHESAPEAKE</b>			4b. City, Town, or Location of Death <b>Anne Arundel</b>			4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>283-18-4825</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>09/01/1916</b>	9. Birthplace (State or Foreign Country) <b>Ohio</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Edgewater</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>315 Oakwood Road</b>			10f. Zip Code <b>21037</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>				
	17. Father's Name (First, Middle, Last) <b>Clarence Louraine White</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sadie Lorane Lewis</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Kathryn E. Brashears/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>315 Oakwood Road, Edgewater, Maryland 21037</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Arlington Nat'l Cem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington Nat'l Cem.</b>		Date <b>09/19/2006</b>	20c. Location - City or Town, State <b>Arlington, Virginia</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):  b. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____ Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>3 MONTHS</b> <b>10 YEARS</b>								
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9 Unknown</b>		23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b> <b>HYPERLIPIDEMIA</b> <b>RENAL FAILURE</b>								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>046360</b>		29d. Date signed (Month, Day, Year) <b>September 7, 2006</b>				
	30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL ANKROM 8601 VETERANS Highway Mickeville, MD 21103</b>								
	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

State  
Registrar

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30681

1- For State  
Registrar**Physician/  
Medical Examiner**1. Decedent's Name (First, Middle, Last)  
**Stanley G. Kroto**

2. Date of Death

Month Day Year  
**September 9, 2006**

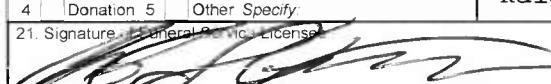
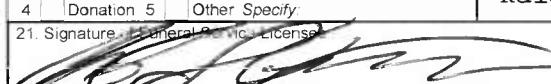
3. Time of Death

**0741 hrs****Funeral  
Director**

4a. Facility Name (if not institution, give street and number) <b>Anne Arundel County Medical Center</b>					4b. City, Town, or Location of Death <b>Annapolis</b>				4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>079-01-3650</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>89</b>	Yrs.	If Under 1 Year Months	If Under 24 Hrs Days	8. Date of Birth (MM/DD/YYYY) <b>4/20/1917</b>	9. Birthplace (State or Foreign Country) <b>New York</b>			

Usual Residence of Decedent  
10a. State  
**Maryland** 10b. County  
**Anne Arundel** 10c. City, Town or Location  
**Annapolis**  
10d. Inside City Limits  
1  Yes 2  No

**To Be Completed by Funeral Director**

10e. Street and Number <b>1044 Pine Crest Drive</b>	10f. Zip Code <b>21403</b>	10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manufacturer's Representative</b>	16b. Kind of Business/Industry <b>Manufacturing</b>	
17. Father's Name (First, Middle, Last) <b>George Kroto</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Margarete Gebhardt</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Fran Kroto/ Wife</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1044 Pine Crest Dr., Annapolis, MD 21403</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify 	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Kalas Crematory</b>	Date <b>9-12-06</b>	20c. Location - City or Town, State <b>Edgewater, MD</b>
21. Signature - Funeral Director License 	22. Name and Address of Facility <b>George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037</b>		

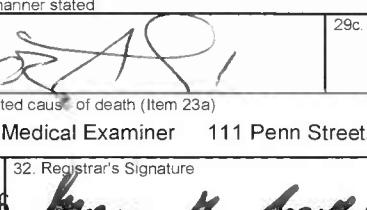
**Baltimore, MD 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Approximate Interval Between Onset and Death			
a. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				
<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth      2 <input type="checkbox"/> Fetal death      3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death      5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA      Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide      4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated	29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 10, 2006</b>	
30. Name and address of person who completed cause of death (Item 23a) <b>Zabiullah Ali, M.D. Assistant Medical Examiner</b>	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature  <b>ORIGINAL</b>	

**State  
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2006 30682

1- For  
State  
Registrar

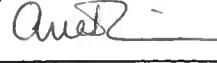
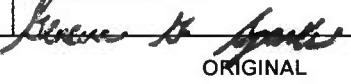
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jane Elizabeth Lyons</i>					2. Date of Death Month Day Year <i>Sept. 12 2006</i>	3. Time of Death <i>10:22 PM</i>
	4a. Facility Name (If not institution, give street and number) <i>Harford Memorial Hospital</i>		4b. City, Town, or Location of Death <i>Havre de Grace</i>			4c. County of Death <i>Harford</i>	
Funeral Director	5. Social Security Number <i>212-22-0054</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>79 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>Oct. 12, 1926</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent 10a. State <i>MD</i>		10b. County <i>Harford</i>			10c. City, Town or Location <i>Havre de Grace</i>	
To Be Completed by Funeral Director	10e. Street and Number <i>210 Alliance Street</i>			10f. Zip Code <i>21078</i>			10g. Citizen of What Country? <i>USA</i>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1948</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 10</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Telephone Operator</i>			16b. Kind of Business/Industry <i>U.S. Government</i>	
17. Father's Name (First, Middle, Last) <i>Charles Leslie Creswell</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Sarah Jane Hines</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Jackie R. Lyons, Sr./husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>210 Alliance Street, Havre de Grace, MD 21078</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Harford Memorial Gardens</i>				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <i>09-15-2006</i>	20c. Location - City or Town, State <i>Aberdeen, Maryland</i>
21. Signature of Funeral Service Licensee <i>Frank. M. Miller</i>				22. Name and Address of Facility R.T. Foard Funeral Home, P.A. <i>111 S. Queen St., Rising Sun, MD 21911</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Cardiac arrest</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. _____							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Coronary artery disease</i> <i>Chronic obstructive pulmonary disease</i>							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Paul Miller, DO</i>				29c. License number <i>6155222</i>			29d. Date signed (Month, Day, Year) <i>September 13, 2006</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Paul Miller DO 501 S. Union Ave Havre De Grace, MD</i>							
31. Date filed (Month, Day, Year) <i>SEP 14 2006</i>		32. Registrar's Signature <i>Paul Miller</i>					

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30683

## 1- For State Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Steven Mark Lippy</b>						2. Date of Death Month Day Year September 20, 2006	3. Time of Death 0745 hrs	
Funeral Director	4a. Facility Name (if not institution, give street and number) <b>Carroll Hospital Center</b>						4b. City, Town, or Location of Death <b>Westminster</b>	4c. County of Death <b>Carroll</b>	
To Be Completed by Funeral Director	5. Social Security Number <b>213-66-5392</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>July 17, 1956</b>	9. Birthplace (State or Foreign Country) <b>PA</b>	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Carroll</b> 10c. City, Town or Location <b>Westminster</b>								
To Be Completed by Funeral Director	10e. Street and Number <b>427 Monterey Drive</b>				10f. Zip Code <b>21157</b>			10g. Citizen of What Country? <b>USA</b>	
Physician /Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married    2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed    4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes    2 <input type="checkbox"/> No <small>If Yes, Give Year or Dates:</small>		13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No <small>specify:</small>			14. Race - American Indian, Black, White, etc. <small>Specify:</small> <b>White</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)      College (1-4 or 5+) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Insurance</b>			16b. Kind of Business/Industry <b>American Family Insurance</b>		
Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036	17. Father's Name (First, Middle, Last) <b>William H. Lippy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Betty Crowl</b>				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	19a. Informant's Name/Relationship (Type, Print) <b>Betty Lippy/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>427 Monterey Drive Westminster, MD 21157</b>				
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit	20a. Method of Disposition 1 <input type="checkbox"/> Burial    2 <input checked="" type="checkbox"/> Cremation    3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation    5 <input type="checkbox"/> Other Specify: <b>Carroll Cremation, Inc</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>9/21/2006</b>	20c. Location - City or Town, State <b>Hampstead, MD</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 								
WJL O	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Fentanyl Intoxication</b> <small>Due to (or as a consequence of):</small> b. <small>Due to (or as a consequence of):</small> c. <small>Due to (or as a consequence of):</small> d. <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED item#23a,27,28a-f,perME,g860, 10/3/06 TT								
Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> Unknown IF FEMALE: 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth    2 <input type="checkbox"/> Fetal death    3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death    5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	23d. Date of delivery Month Day Year								
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Probably    4 <input checked="" type="checkbox"/> Unknown								
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes    2 <input type="checkbox"/> No    24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes    2 <input type="checkbox"/> No								
WJL O	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes    2 <input type="checkbox"/> No								
Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient    2 <input checked="" type="checkbox"/> ER/Outpatient    3 <input type="checkbox"/> DOA    Other: 4 <input type="checkbox"/> Nursing Home    5 <input type="checkbox"/> Residence    6 <input type="checkbox"/> Other: <b>subject ingested pills</b>								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	27. Manner of Death 1 <input type="checkbox"/> Natural    5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident    6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide    7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide								
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit	28a. Date of Injury (Month, Day, Year) <b>Fnd 9/19/2006</b>								
Medical Certification: To Be Completed by Physician/Medical Examiner	28b. Time of Injury <b>Fnd 11:16 am</b>								
WJL O	28c. Injury at Work? 1 <input type="checkbox"/> Yes    2 <input checked="" type="checkbox"/> No								
Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>House</b>								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>427 Monterey Drive Westminster, MD</b>								
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <small>Check only one</small> 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
WJL O	29b. Signature and title of certifier 								
Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036	29c. License number <b>O.C.M.E.</b>								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	29d. Date signed (Month, Day, Year) <b>September 21, 2006</b>								
WJL O	30. Name and address of person who completed cause of death (Item 23a) <b>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>								
Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036	31. Date filed (Month, Day, Year) <b>SEP 22 2006</b>								
WJL O	32. Registrar's Signature  ORIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30684

For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month 09 Day 17 Year 06 1650 M	3. Time of Death
	Leonard Wayne McNemar			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany		
Funeral Director	4a. Facility Name (If not institution, give street and number) WMHS Braddock Campus			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany		
To Be Completed by Funeral Director	5. Social Security Number 213-22-3942	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 6, 1928	9. Birthplace (State or Foreign Country) Rowlesburg, WV		
	Usual Residence of Decedent 10a. State WV 10b. County Mineral			10c. City, Town or Location Keyser			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 56 Maple Avenue			10f. Zip Code 26726			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean Conflict	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Quality Control Supervisor				16b. Kind of Business/Industry Nuclear energy production			
	17. Father's Name (First, Middle, Last) Harold B. McNemar			18. Mother's Name (First, Middle, Maiden Surname) Carrie M. Trenum					
	19a. Informant's Name/Relationship (Type, Print) Effie M. McNemar / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 Maple Avenue Keyser, Wv 26726					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Thrush Cemetery	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date Sept. 21	20c. Location - City or Town, State Antioch, WV					
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee ► Brian Smith	22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Approximate Interval Between Onset and Death 2 DAYS							
	a. Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION								
	b. Due to (or as a consequence of): CORONARY ARTERY DISEASE								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier ► Dr. Physician	29c. License number DS0844			29d. Date signed (Month, Day, Year) 09/18/06				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSE J. LOVINS, JR., MD 912 SETON DRIVE CUMBERLAND, MD 21502								
State Registrar	31. Date filed (Month, Day, Year) SEP 18 2006	32. Registrar's Signature John B. Lovins							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30685

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death						
Ruth Mary McNicol		September 16 2006				1:35 PM						
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death						
Solomons Nursing Center		Solomons				Calvert						
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 10/12/1914	9. Birthplace (State or Foreign Country) West Virginia					
229-36-1628												
Usual Residence of Decedent		10a. State Maryland				10b. County Calvert		10c. City, Town or Location Solomons	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 13121 Windjammer Ave.		10f. Zip Code 20688				10g. Citizen of What Country? United States						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry Accountant								
17. Father's Name (First, Middle, Last) Wilfred Garner Gough		18. Mother's Name (First, Middle, Maiden Surname) Ruth Marian White										
19a. Informant's Name/Relationship (Type, Print) Judy Vaughn / Friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12123 Gringo Road Lusby, Maryland 20657										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Christ Episcopal Cem		20c. Date 9-23-2006			20c. Location - City or Town, State Chaptico, Maryland					
21. Signature of Funeral Service Licensee ► Kyle S. Simons M01206		22. Name and Address of Facility Brinsfield Funeral Home PA. 22955 Hollywood Road Leonardtown, Maryland 20650										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fatal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 043306				29d. Date signed (Month, Day, Year) 9/18/06						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Batong 11845 H. G. Truman Road Lusby, Maryland 20657												
31. Date filed (Month, Day, Year) SEP 20 2006		32. Registrar's Signature [Signature]										

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2006 30686

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth M. Maykrantz</b>						2. Date of Death Month Day Year <b>September 8 2006</b>	3. Time of Death <b>1:43 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Heritage Harbour Health &amp; Rehab. Ctr.</b>			4b. City, Town, or Location of Death <b>Annapolis</b>			4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>578-38-2034</b>	6. Sex <b>1 ♂ M 2 ♀ F</b>	7. Age (In yrs. last birthday) <b>91 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>12/15/1914</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Davidsonville</b>						10d. Inside City Limits <b>1 Yes 2 No</b>		
10e. Street and Number <b>3913 Birdsville Road</b>				10f. Zip Code <b>21035</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No If Yes, Give Year or Dates: 12</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Title Clerk</b>			16b. Kind of Business/Industry <b>Automobile</b>			
17. Father's Name (First, Middle, Last) <b>Earl Collingsworth</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Ruppel</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Joseph E. Herring/Grandchild</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>916 Rhode Harbor Rd. Edgewater, MD 21037</b>					
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Kalas Crematory</b>			Date <b>09/09/2006</b>	20c. Location - City or Town, State <b>Edgewater, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home <b>2973 Solomons Island Rd., Edgewater, MD 21037</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>15</b>	
<p>a. Due to (or as a consequence of):  <i>Ventricular fibrillation</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown</b>				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>	
								24a. Was an autopsy performed? <b>1 Yes 2 No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
27. Manner of Death <b>1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? M 1 Yes 2 No		28d. Describe how injury occurred	
								28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, MD 21215</b>
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>									
29b. Signature and title of certifier 		29c. License number <b>D 32036</b>			29d. Date signed (Month, Day, Year) <b>9/8/2006</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gary Sprague 2107 D. Ward Dr. in Cheveron, MD 21619</b>									
31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

## Medical Certification: To Be Completed by Physician/Medical Examiner

## To Be Completed by Funeral Director

1- For  
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2006 30687

Physician  
/Medical  
ExaminerFuneral  
Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

		1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year			3. Time of Death	
		Simone Meraldi						September 17, 2006			9:28 p.m.	
		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death				
		14940 Chesapeake Bay Drive			Scotland			St. Mary's				
		5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Sept. 22, 1938	9. Birthplace (State or Foreign Country) France	
		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Scotland					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 14940 Chesapeake Bay Drive				10f. Zip Code 20687				10g. Citizen of What Country? United States		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Administrator			Banking			
		17. Father's Name (First, Middle, Last) Joseph LeFloch				18. Mother's Name (First, Middle, Maiden Surname) Marianne LeBris						
		19a. Informant's Name/Relationship (Type, Print) Pascale Meraldi / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4941 Pleasant Grove Road, Reisterstown, MD 21136						
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols Cr. 9-20-2006		20c. Location - City or Town, State Charlotte Hall, MD				
		21. Signature of Funeral Service Licensee ► Kyle S. Simons MUIZ06				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279						
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death						
		<p>a. <i>Lung Cancer</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number H0055751						29d. Date signed (Month, Day, Year) 9/20/106		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O., 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650										
		31. Date filed (Month, Day, Year) SEP 20 2006						32. Registrar's Signature <i>Jennifer Schmidt</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30688

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

MLYNARSKI, Bruce, Maryland 21215-0036  
Baltimore, Maryland 21215-0036  
Permit Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28-a-1 show  
any injury or other traumatic event, the Medical Examiner shall be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
service.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
BRUCE Joseph Mlynarski		SEPT. 13, 2006		6646 M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Peninsula Regional Medical Center		Salisbury		Nicomico
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days Hours Min.
139-36-8242				
Usual Residence of Decedent		8. Date of Birth (Month, Day, Year) 2-9-1945		9. Birthplace (State or Foreign Country) NJ
10a. State VA	10b. County Accomack	10c. City, Town or Location Chincoteague		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 8278 Bay Side Lane		10f. Zip Code 23336		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Manager		16b. Kind of Business/Industry Acme Markets
17. Father's Name (First, Middle, Last) Frank Mlynarski Sr.		18. Mother's Name (First, Middle, Maiden Surname) Ann Cetera		
19a. Informant's Name/Relationship (Type, Print) Patricia Mlynarski /wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8278 Bay Side Lane Chincoteague, VA 23336		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Occohannock Crematory 9113106		Date
21. Signature of Funeral Service Licensee ► Amanda C. Betts		22. Name and Address of Facility Salyer Funeral Home, Inc. 6327 Church St.		20c. Location - City or Town, State Chincoteague, VA 23336
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Severe head trauma		Approximate Interval Between Onset and Death 480
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): Ground (evel) fall		
		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. _____		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 9/11/06	28b. Time of Injury Work? NOON M 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Fall
28e. Place of Injury : At home, farm, street, factory, office building, etc. (Specify) Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 8278 Dayside Lane VA		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 1450497		29d. Date signed (Month, Day, Year) 9/13/06
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Snyder DO 100 E. CARROLL ST. SALISBURY MD 21801				
31. Date filed (Month, Day, Year) SEP 14 2006		32. Registrar's Signature Bruce H. Apelt		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30689

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stewart Lee Neff</b>							2. Date of Death Month Day Year <b>September 12, 2006</b>	3. Time of Death P <b>8:40</b>	
	4a. Facility Name (If not institution, give street and number) <b>112 S. Camden Ave.</b>				4b. City, Town, or Location of Death <b>Fruitland</b>			4c. County of Death <b>Wicomico</b>		
Funeral Director	5. Social Security Number <b>215-62-2394</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>4/21/1955</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b>							10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Fruitland</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>112 S. Camden Ave.</b>				10f. Zip Code <b>21826</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1960</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Exterminator</b>			16b. Kind of Business/Industry <b>Exterminating</b>		
	17. Father's Name (First, Middle, Last) <b>Charles Ed Neff</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Willey</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Pam L. Neff/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>112 S. Camden Ave., Fruitland, MD 21826</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Kurt R. Darsay CESP</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Zion Cemetery</b>			Date <b>9/16/06</b>	20c. Location - City or Town, State <b>Eden, MD</b>	
	21. Signature of Funeral Service Licensee <b>Kurt R. Darsay CESP</b>				22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying Cause (Disease or injury that initiated events resulting in death) <b>Cirrhosis of the Liver</b>							Approximate Interval Between Onset and Death		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		
	23d. Date of delivery Month Day Year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							28a. Date of Injury (Month, Day Year) <b>M</b>		
								28b. Time of Injury <b>M</b>		
								28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>							28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Seaford, MD 21802</b>		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier <b>Dale E. Powell, MD</b>		
								29c. License number <b>026278</b>		
								29d. Date signed (Month, Day, Year) <b>9-13-06</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dale E. Powell, MD Coastal Hospit po Box 1733 Seaford, MD 21802</b>									
	31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>							32. Registrar's Signature <b>James M. Apodaca</b>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30690

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernadine Farrell Orr</b>							2. Date of Death Month Day Year <b>September 20, 2006</b>	3. Time of Death <b>1030 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>124 Porter Road</b>			4b. City, Town, or Location of Death <b>North East</b>			4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>220-42-9957</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>AUG 12, 1947</b>	9. Birthplace (State or Foreign Country) <b>Ohio</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Cecil</b> 10c. City, Town or Location <b>North East</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>124 Porter Road</b>			10f. Zip Code <b>21901</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify:		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>In Her Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Farrell Bernard McTheny</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Evelyn Sears</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Boyd D. Orr/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>124 Porter Road, North East, MD 21901</b>				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► James S. Hicks</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Immaculate Conception Cemetery</b>		Date <b>September 23, 2006</b>	20c. Location - City or Town, State <b>Cherry Hill, Maryland</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>James S. Hicks</b>		22. Name and Address of Facility <b>Hicks Home for Funerals, P.A.</b> <b>103 W. Stockton St., Elkton, MD 21921</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>2 years</b>						
	a. <b>Breast cancer</b> Due to (or as a consequence of):								
	b. _____ Due to (or as a consequence of):								
	c. _____ Due to (or as a consequence of):								
	d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier <input type="checkbox"/> Doctor only <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>J. Khatri</b>					29c. License number <b>D54086</b>	
								29d. Date signed (Month, Day, Year) <b>9/21/2006</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jamil Khatri, MD 111 W. High St Ste 104 Elkton, MD 21921</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature <b>James S. Hicks</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30691

Certificate of Death

Reg. No.

For  
State  
Registrar

1 -

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Lawrence O'Brate</b>							2. Date of Death Month Day Year <b>September 13, 2006</b>	3. Time of Death <b>0932 A M</b>		
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>				4b. City, Town, or Location of Death <b>Olney</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>441-09-2654</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug 14, 1919</b>	9. Birthplace (State or Foreign Country) <b>Oklahoma</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Silver Spring</b>								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3560 Chiswick Court</b>				10f. Zip Code <b>20906</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-46</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Executive</b>			16b. Kind of Business/Industry <b>Federal Government</b>			
	17. Father's Name (First, Middle, Last) <b>Anthony Hendricks O'Brate</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Elizabeth Payne</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>James O'Brate/son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3560 Chiswick Court Silver Spring, MD 20906</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>M01251</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>09/15/06</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>				
	21. Signature of Funeral Service Licensee <b>Beverly L. Heckrotte</b>				22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Myocardial Infarction</b>								Approximate Interval Between Onset and Death <b>6 days</b>		
	a. Due to (or as a consequence of): <b>Myocardial Infarction</b>										
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>Unknown</b>					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Hypertension</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) <b>9/13/2006</b>		
	29b. Signature and title of certifier <b>Shyam Parkhie, M.D.</b>								29c. License number <b>68168</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shyam Parkhie, M.D. 18101 Prince Philip Dr. Olney, MD 20832</b>								31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>		
	32. Registrar's Signature <b>Karen B. Park</b>								33. Date signed (Month, Day, Year)		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at 410-727-5000.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

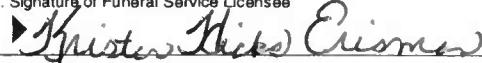
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30692

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lois Jean Popkey</b>							2. Date of Death Month Day Year <b>September 20, 2006</b>	3. Time of Death <b>0820 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>56 Vanderlyn Drive</b>			4b. City, Town, or Location of Death <b>Chesapeake City</b>			4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>184-24-6805</b>	6. Sex <b>1 □ M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>74 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day, Year) <b>OCT 27, 1931</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
Usual Residence of Decedent									
	10a. State <b>Maryland</b>	10b. County <b>Cecil</b>	10c. City, Town or Location <b>Chesapeake City</b>					10d. Inside City Limits <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>	
10e. Street and Number <b>56 Vanderlyn Drive</b>				10f. Zip Code <b>21915</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <b>1 □ Never Married 2 <input checked="" type="checkbox"/> Married 3 □ Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>In Her Own Home</b>	
	17. Father's Name (First, Middle, Last) <b>Ike Davies</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Shenrock</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Herbert R. Popkey/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>56 Vanderlyn Drive, Chesapeake City, MD 21915</b>				
	20a. Method of Disposition <b>1 □ Burial 2 <input checked="" type="checkbox"/> Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris &amp; Co., Inc.</b>		Date <b>September 21, 2006</b>	20c. Location - City or Town, State <b>West Chester, PA</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>years</b>				
	<p>a. Due to (or as a consequence of):  <b>Chronic obstructive pulmonary disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No 9 □ Unknown</b>				23c. If yes, outcome of pregnancy <b>1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)</b>			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 □ No 3 <input checked="" type="checkbox"/> Probably 4 □ Unknown</b>				
					24a. Was an autopsy performed? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>				
					24b. Were autopsy findings available prior to completion of cause of death? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>				
	25. Was case referred to medical examiner? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>				26. Place of Death (Check only one) Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 □ Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 □ Other (Specify)</b>				
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 □ Accident 3 □ Suicide 4 □ Homicide</b>				28a. Date of Injury (Month, Day Year) <b>5 □ Pending investigation</b>		28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 □ Yes 2 □ No</b>	28d. Describe how injury occurred
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Suite 101 111 west High Street Elkton MD 21921</b>		
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>				29c. License number <b>D0047471</b>				
					29d. Date signed (Month, Day, Year) <b>September 20th, 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joshua N. Aaron MD</b>				32. Registrar's Signature <b>June 21 April</b>				
	31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30693

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ronald C. Parker</b>							2. Date of Death Month Day Year <b>September 7 2006</b>	3. Time of Death 9:40 AM
	4a. Facility Name (If not institution, give street and number) <b>Berlin Nursing &amp; Rehab Center</b>			4b. City, Town, or Location of Death <b>Berlin</b>			4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number <b>219-44-1273</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 18, 1945</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent		10a. State <b>MD</b> 10b. County <b>Worcester</b>			10c. City, Town or Location <b>Pocomoke</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>1210 Market St., Apt. G2</b>			10f. Zip Code <b>21851</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>			16b. Kind of Business/Industry <b>Lumber</b>		
	17. Father's Name (First, Middle, Last) <b>Wilton J. Parker</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Mae Armstrong</b>					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Maggie Holland/friend</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1210 Market St., Apt. G2, Pocomoke, MD 21851</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crematory of Delmarva</b>			Date <b>9/14/2006</b>	20c. Location - City or Town, State <b>Delmar, DE</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Lewis N. Watson Funeral Home</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): <b>Metastatic Prostate Cancer</b>			Approximate Interval Between Onset and Death <b>Years</b>		
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>D28169</b>			29d. Date signed (Month, Day, Year) <b>9/18/06</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nicholas Borodukay, MD 1209 Coastal Highway Fenwick Island, DE 19944</b>			32. Registrar's Signature 			31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30694

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Truman Quade</b>							2. Date of Death Month Day Year <b>SEPTEMBER 16 2006</b>	3. Time of Death 11:27 pm	
	4a. Facility Name (If not institution, give street and number) <b>St. Mary's Hospital</b>			4b. City, Town, or Location of Death <b>Leonardtown</b>			4c. County of Death <b>Saint Marys</b>			
Funeral Director	5. Social Security Number <b>213-22-0083</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 15, 1920</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Saint Marys</b> 10c. City, Town or Location <b>Chaptico</b>									10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>24099 Maddox Road</b>			10f. Zip Code <b>20621</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Waterman</b>		16b. Kind of Business/Industry <b>Self Employed</b>					
	17. Father's Name (First, Middle, Last) <b>Bruce Johnson Quade</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Milburn Farrell</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Rose Lee Thompson/Sister</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20885 Oakland Hall Road Avenue, Maryland 20609</b>				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Charles Memorial Gardens</b>			Date <b>September 20, 2006</b>	20c. Location - City or Town, State <b>Leonardtown, Maryland</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street Leonardtown, Maryland 20650</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>Cardio respiratory Failure</b> <b>Renal failure</b>			Approximate Interval Between Onset and Death				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): <b>I bleed</b> Due to (or as a consequence of): <b>CHF</b>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D 47066</b>			29d. Date signed (Month, Day, Year) <b>9-17-06</b>				
	29b. Signature and title of certifier 									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A.D. Shah St. Marys Med. Art Building, Leonardtown, Maryland 20650</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 19 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CHARLES TRUMAN QUADE,  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

*Baker*

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30695  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mae Helen Bennett</b>							2. Date of Death Month Day Year <b>SEPTEMBER 14 2006</b>	3. Time of Death <b>3:53 A M</b>						
	4a. Facility Name (If not institution, give street and number) <b>St. Mary's Hospital</b>				4b. City, Town, or Location of Death <b>Leonardtown</b>			4c. County of Death <b>St. Mary's</b>							
Funeral Director	5. Social Security Number <b>220-42-4761</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>June 8, 1943</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
	10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Scotland</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number <b>49458 Fresh Pond Neck Road</b>				10f. Zip Code <b>20687</b>			10g. Citizen of What Country? <b>United States</b>							
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>2</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4or 5+)</b> <b>2</b> <b>Teacher Aide</b>			16b. Kind of Business/Industry <b>Education</b>								
	17. Father's Name (First, Middle, Last) <b>Guffrie Matthew Smith, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Parthenia W. Barnes</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>Robert S. Bennett / Husband</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>49458 Fresh Pond Neck Road, Scotland, Maryland 20687</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Edward N. Brinsfield Jr. M00052</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Luke's Cemetery</b>			Date <b>9-19-2006</b>	20c. Location - City or Town, State <b>Scotland, Maryland</b>							
	21. Signature of Funeral Service Licensee <b>Edward N. Brinsfield Jr.</b>					22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A.</b>									
To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metastatic cancer of Throat</b>										Approximate Interval Between Onset and Death <b>one year</b>				
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										23d. Date of delivery Month Day Year				
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			26. Place of Death (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>M</b>								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <b>M</b>			28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <b>SC Gaby M.D.</b>			29c. License number <b>D54346</b>	29d. Date signed (Month, Day, Year) <b>9/14/06</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. CHANDRA SAJJA PO BOX 640 HOLLYWOOD MD. 20636</b>														
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 18 2006</b>			32. Registrar's Signature <b>[Signature]</b>			ORIGINAL								

Baltimore, Maryland 21215-0036  
 Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene  
 Important: If Item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

MAE HELEN BENNETT  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene  
 Important: If Item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30696

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES

RIMEL

2. Date of Death

Month

Day

Year

3. Time of Death

0153 AM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

220-24-9632

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

05/04/1928

9. Birthplace (State or Foreign Country)

Virginia

Funeral  
Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

519 Aldino-Stepney Road

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1  Never Married 2  Married3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Government

16b. Kind of Business/Industry

Civil Service

17. Father's Name (First, Middle, Last)

John Lawrence Rimel

18. Mother's Name (First, Middle, Maiden Surname)

Hattie May Cassell

19a. Informant's Name/Relationship (Type, Print)

Kimberly R. Rimel (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

259 W. Broadway, Red Lion, PA 17356

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

R.A. Ferris &amp; Co., Inc. 09/25/2006 W. Chester, PA

21. Signature of Funeral Service Licensee

Dana C. Bellman

22. Name and Address of Facility

Tanning-Cargo Funeral Home, P.A.

333 South Park St., Aberdeen, Maryland 21001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Pneumonia

Due to (or as a consequence of):

Due to (or as a consequence of):

d.

2 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy4  Pregnant at time of death5  Other (specify) 9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic Stenosis

Atherosclerosis choleystitis

Coronary disease

Renal failure

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?

1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural2  Accident3  Suicide4  Homicide5  Pending investigation6  Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1  Yes 2  No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kelly Olin

RES-000

September 22, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kelly Olin 600 N Wolfe St Baltimore, MD 21287

31. Date filled (Month, Day, Year)

SEP 27 2006

32. Registrar's Signature

Laura B. Spotts

6-1

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend #11 Per INF G860 10/02/06 JH  
1- For State Registrar Certificate of Death Reg. No. 2006 30697

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AVIS DENSMORE STUART</b>							2. Date of Death Month Day Year <b>September 17, 2006</b>	3. Time of Death 10:45 PM
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Frederick</b>			4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>193-18-8474</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>May 30, 1922</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b>			10b. County <b>Frederick</b>			10c. City, Town or Location <b>Frederick</b>		
	10e. Street and Number <b>5591 Teakwood Court</b>			10f. Zip Code <b>21701</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b> 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clinical Psychologist</b>			16b. Kind of Business/Industry <b>University</b>		
	17. Father's Name (First, Middle, Last) <b>Unknown</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Elizabeth Densmore</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>David E. Stuart, son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>423 Tulane Drive, SE, Albuquerque, NM 87106</b>			Date <b>9/24/2006</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Ryan M. Berger</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>East Oak Grove Cem.</b>			20c. Location - City or Town, State <b>Morgantown, West Virginia</b>		
	21. Signature of Funeral Service Licensee <b>Ryan M. Berger</b>			22. Name and Address of Facility <b>Keeney and Basford Funeral Home</b>					
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			Approximate Interval Between Onset and Death <b>Acute myocardial infarction</b>		
Physician /Medical Examiner	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Moderate to severe dementia, Diabetic retinopathy, Hypertension, Abdominal Aortic Aneurysm, Urinary Tract Infection</b>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was this case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>D21944</b>			29d. Date signed (Month, Day, Year) <b>9/20/06</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James S. Grissom MD 1475 TANEY AVE. #204 FREDERICK, MD. 21702</b>			31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>			32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2006 30698

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Charlotte S. Thompson</i>					2. Date of Death Month <i>September</i> Day <i>9<sup>th</sup></i> Year <i>2006</i>		3. Time of Death <i>08:25 AM</i>
	4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i>					4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>HOWARD</i>
Funeral Director	5. Social Security Number <i>579-36-6693</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>84 Yrs.</i>	If Under 1 Year Months <input type="checkbox"/> Days Hours Min.	If Under 24 Hrs. Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) <i>Oct 20, 1921</i>	9. Birthplace (State or Foreign Country) <i>North Dakota</i>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>Howard</i> 10c. City, Town or Location <i>Columbia</i> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number <i>6336 Cedar Lane #274</i>				10f. Zip Code <i>21044</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1946</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>	14. Race - American Indian, Black, White, etc.				
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>School Teacher</i>	16b. Kind of Business/Industry <i>Education</i>				
	17. Father's Name (First, Middle, Last) <i>Olaf Barnhard Skonnord</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Bergine Skonnord</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Allan G. Thompson/husband</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6336 Cedar Lane #274 Columbia, MD 21044</i>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Chesapeake Crematory</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Chesapeake Crematory</i>	Date <i>09/12/06</i>	20c. Location - City or Town, State <i>Beltsville, MD</i>		
	21. Signature of Funeral Service Licensee <i>Beverly L. Heckrotte</i>			22. Name and Address of Facility <i>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</i>				
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Bronchiectasis</i> Approximate Interval Between Onset and Death							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Pneumonia</i> <i>Chronic Obstructive airway disease</i> <i>Hypertension</i>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Suzen Abdo</i>				29c. License number <i>D50870</i>		29d. Date signed (Month, Day, Year) <i>September 9<sup>th</sup> 2006</i>	
	31. Date filed (Month, Day, Year) <i>SEP 14 2006</i>		32. Registrar's Signature <i>Maura B. Jones</i>					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event,  Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8/22

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

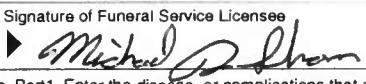
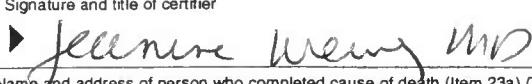
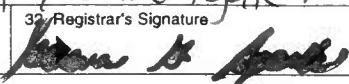
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2006 30699

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Bagley Talbot</b>					2. Date of Death Month Day Year <b>September 10, 2006</b>	3. Time of Death <b>12:20 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>680 Americana Drive Apt 43</b>			4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>216-34-6191</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 5, 1936</b>	9. Birthplace (State or Foreign Country) <b>Washington D.C.</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b>			10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>680 Americana Drive Apt 43</b>			10f. Zip Code <b>21403</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Elementary/Secondary (0-12)</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Pastor</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Ministry</b>			16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) <b>Clarence Claiborne Bagley</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Emily Skillman</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>William C. Soper / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1091 Carson Drive, Huntingtown, Maryland 20639</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Ft. Lincoln Cemetery</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		Date <b>9/12/2006</b>	20c. Location - City or Town, State <b>Brentwood, Maryland</b>		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Ovary Cancer</b>							Approximate Interval Between Onset and Death	
	23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one) <input type="checkbox"/> At home, farm, street, factory, office building, etc. (Specify) <b>At home, farm, street, factory, office building, etc. (Specify)</b>		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>Sept 12 2006</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
								28d. Describe how injury occurred	
								28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>900 Bestgate Road #300, Annapolis, MD 21401</b>	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 							29c. License number <b>DS2830</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeannine Werner, 900 Bestgate Road #300, Annapolis, MD 21401</b>							29d. Date signed (Month, Day, Year) <b>September 11, 2006</b>	
	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>							32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30700

Reg. No.

1 - For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

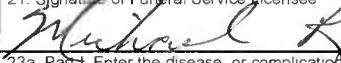
1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
<i>Alice Vernon White</i>		<i>September 2, 2006</i>				<i>4:30 P M</i>	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
<i>Holy Cross Hospital</i>		<i>Silver Spring</i>				<i>Montgomery</i>	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>96</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.
10a. State <i>D.C.</i>		10b. County		10c. City, Town or Location <i>Washington</i>			
10e. Street and Number <i>5402 Call Place, S.E.</i>				10f. Zip Code <i>20019</i>		10g. Citizen of What Country? <i>U.S.</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>5+</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Russian Translator/Teacher</i>				16b. Kind of Business/Industry <i>Education</i>	
17. Father's Name (First, Middle, Last) <i>Unknown</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Unknown</i>					
19a. Informant's Name/Relationship (Type, Pri <i>Patrice N. Strapp-White</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>15 R ST. NW., Washington, D.C. 20001</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Harmony Memorial PK</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>9-15-06 Landover, Maryland</i>				20c. Location - City or Town, State <i>Landover, Maryland</i>	
21. Signature of Funeral Service Licensee <i>Joe M. Turner</i>		22. Name and Address of Facility <i>Connie &amp; Associates Funeral Home 2504 20th St. N.E. WDC 20018</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebrovascular disease</i> Due to (or as a consequence of): b. <i>Respiratory Failure</i> Due to (or as a consequence of): c. <i>Severe Sepsis</i> Due to (or as a consequence of): d. _____							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier <i>Maria J. Tayag</i>		29c. License number <i>DB635579</i>				29d. Date signed (Month, Day, Year) <i>09/02/2006</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Maria J. Tayag 1500 Forest Glen Rd. Silver Spring, MD 20910</i>							
31. Date filed (Month, Day, Year) <i>SEP 27 2006</i>		32. Registrar's Signature <i>Maria J. Tayag</i>					

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg No.

2006 30701

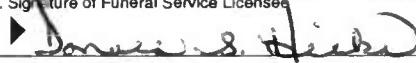
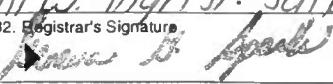
1- For State  
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>DEBORAH ELIZABETH WALD</b>				2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> September 14, 2006		3. Time of Death 0710 hrs	
Funeral Director		4a. Facility Name (if not institution, give street and number) <b>19801 Three Notch Road Apt. 8</b>				4b. City, Town, or Location of Death <b>Lexington Park</b>		4c. County of Death <b>St. Mary's</b>	
To Be Completed by Funeral Director		5. Social Security Number <b>213-82-6890</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>36</b> Yrs		If Under 1 Year Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. <b>SEPT. 4, 1970</b>	
To Be Completed by Funeral Director		8. Date of Birth (MM/DD/YYYY)		9. Birthplace (State or Foreign Country)		<b>MARYLAND</b>			
To Be Completed by Physician/Medical Examiner		10a. State <b>MARYLAND</b>		10b. County <b>ST. MARY'S</b>		10c. City, Town or Location <b>LEXINGTON PARK</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		10e. Street and Number <b>19801 THREE NOTCH RD., APT. 6</b>				10f. Zip Code <b>20653</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No <small>If Yes, Give Year or Dates</small>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No <small>specify</small>		14. Race - American Indian, Black, White, etc. <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) <b>CHARLES STANLEY WALD, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET LINDA DODSON</b>			
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>PAULA WALD - SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9209 MONTGOMERY POST PL., NANJEMOY, MD 20662</b>			
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <b>METROPOLITAN CREMATORY</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>9-20-06</b>		20c. Location - City or Town, State <b>ALEXANDRIA, VIRGINIA</b>	
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>RAYMOND FUNERAL SERVICE, P.A.</b> <b>LA PLATA, MARYLAND 20646</b>			
To Be Completed by Physician/Medical Examiner		23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Intracerebral Hemorrhage</b> <small>Due to (or as a consequence of):</small>				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner		<b>b.</b> <small>Due to (or as a consequence of):</small>							
To Be Completed by Physician/Medical Examiner		<b>c.</b> <small>Due to (or as a consequence of):</small>							
To Be Completed by Physician/Medical Examiner		<b>d.</b> <small>Due to (or as a consequence of):</small>							
To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year			
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension; End Stage Renal Disease; Congestive Heart Failure</b>				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene					
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. <small>(Specify)</small>				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated							
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 15, 2006</b>	
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30702  
Certificate of Death  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Dorothy Wagner</b>							2. Date of Death Month Day Year <b>September 21, 2006</b>	3. Time of Death <b>05:45 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>24 Brownfield Loop, Caraway Manor</b>			4b. City, Town, or Location of Death <b>Elkton</b>			4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>157-26-1518</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>95</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>May 18, 1911</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent 10a. State <b>New Jersey</b>			10b. County <b>Somerset</b>			10c. City, Town or Location <b>Hillsborough</b>		
10e. Street and Number <b>2 Davids Lane</b>				10f. Zip Code <b>08844</b>			10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Seamstress</b>			16b. Kind of Business/Industry <b>Garment</b>			
17. Father's Name (First, Middle, Last) <b>Vincent Steller</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Stakionis</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Clifford R. Wagner/Son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Davids Lane, Hillsborough, New Jersey 08844</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rosedale Cemetery</b>			Date <b>September</b>	20c. Location - City or Town, State <b>Linden, New Jersey</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>2 months</b>
<p>a. <b>Failure to thrive</b> Due to (or as a consequence of): <i>Dementia</i></p> <p>b. Due to (or as a consequence of): <i>Dementia</i></p> <p>c. Due to (or as a consequence of): <i>Dementia</i></p> <p>d.</p>									<b>2 years</b>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dysphagia</b>									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>DAV59324</b>			29d. Date signed (Month, Day, Year) <b>September 22, 2006</b>			
29b. Signature and title of certifier 			32. Registrar's Signature 						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Renee Perkins no 111 W. High St. Suit 314 Elkton, MD 21921</b>			31. Date filed (Month, Day, Year) <b>SEP 27 2006</b>			32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30703

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or if items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Eugene Eager Wood		September 17, 2006				8:45 a.m.	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
St. Mary's Nursing Center		Leonardtown				St. Mary's	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) May 12, 1925	9. Birthplace (State or Foreign Country) Virginia
10a. State Maryland		10c. City, Town or Location California				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 22011 Victorian Drive		10f. Zip Code 20619				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Episcopal Priest		16b. Kind of Business/Industry Religion			
17. Father's Name (First, Middle, Last) Eugene Eager Wood		18. Mother's Name (First, Middle, Maiden Surname) Charlotte Ayler					
19a. Informant's Name/Relationship (Type, Print) Nell W. Wood / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22011 Victorian Drive, California, Maryland 20619					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Andrew's Cemetery		Date	20c. Location - City or Town, State 9-21-2006 California, Maryland		
21. Signature of Funeral Service Licensee ► Kyle S. Simons M01200		22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. { a. Due to (or as a consequence of): Carcinosarcoma b. Due to (or as a consequence of): Prostate Cancer c. Due to (or as a consequence of): d. Due to (or as a consequence of): Coronary Artery Disease Approximate Interval Between Onset and Death months 1 yr +					
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 06419					
29b. Signature and title of certifier ► James P. Jarboe, M.D.		29d. Date signed (Month, Day, Year) 9-18-06					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636							
31. Date filed (Month, Day, Year) SEP 20 2006		32. Registrar's Signature James P. Jarboe					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

2006 30704

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Maude Ruark Warrington</b>							2. Date of Death Month <b>09</b> Day <b>11</b> Year <b>2006</b>	3. Time of Death <b>11:23 P M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Coastal Hospice at the Lake</b>				4b. City, Town, or Location of Death <b>Salisbury</b>			4c. County of Death <b>Wicomico</b>		
Funeral Director	5. Social Security Number <b>213-16-8931</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month/Day/Year) <b>9/24/1921</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Wicomico</b> 10c. City, Town or Location <b>Salisbury</b>								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>6758 Walston Switch Road</b>				10f. Zip Code <b>21804</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		College (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>			16b. Kind of Business/Industry <b>Shirt Factory</b>		
	17. Father's Name (First, Middle, Last) <b>Jerome Samuel Moore</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Timmons</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Manaeen F. Warrington III/son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>32170 Bonhill Dr., Salisbury, MD 21804</b>				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parsons Cemetery</b>			Date <b>9/16/06</b>	20c. Location - City or Town, State <b>Salisbury, MD</b>			
	21. Signature of Funeral Service Licensee <b>Kathy R. Dorey CFS</b>		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Malignant Melanoma</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
	b. _____ Due to (or as a consequence of):									
	c. _____ Due to (or as a consequence of):									
	d. _____ Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 5 <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>David E. Carroll, MD</b>							
			29c. License number <b>D26278</b>							
			29d. Date signed (Month, Day, Year) <b>9-12-06</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David E. Carroll, MD Coastal Hospice PO Box 1733 Salisbury, MD 21802</b>		31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>							
			32. Registrar's Signature <b>Debbie A. Spotts</b>							

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30705

1- For State  
Registrar**Physician/  
Medical Examiner**

8440		1. Decedent's Name (First, Middle, Last) <b>David Michael Wahl</b>						2. Date of Death Month <b>September</b> Day <b>19</b> Year <b>2006</b>	3. Time of Death 0812 hrs		
		4a. Facility Name (if not institution, give street and number) <b>Frederick Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Frederick</b>			4c. County of Death <b>Frederick</b>			
Funeral Director		5. Social Security Number <b>218-72-4127</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>47</b> Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (MM/DD/YYYY) <b>June 21, 1959</b>	9. Birthplace (State or Foreign Country) <b>Missouri</b>			
		Usual Residence of Decedent <b>Maryland Frederick</b>			10c. City, Town or Location <b>Point of Rocks</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director		10e. Street and Number <b>3813 Pippins Place</b>			10f. Zip Code <b>21777</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify <b>White</b>			14. Race - American Indian, Black, White, etc.
Baltimore, MD 21215-0036		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>brick &amp; stone mason</b>			16b. Kind of Business/Industry <b>construction</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Sherry Wahl/ wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3813 Pippins Place Point of Rocks, MD 21777</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Culler</b>			
Physician / Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Catherine O. Hartzler</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Luke's Luth. Cem.</b>			Date <b>9/23/2006</b>	20c. Location - City or Town, State <b>Feagerville, MD</b>		
		21. Signature of Funeral Service Licensee <i>Catherine O. Hartzler</i>			22. Name and Address of Facility <b>Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762</b>						
Medical Certification: To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic cardiovascular disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED item#23a,27,perME,g860,10/3/06 TT									Approximate Interval Between Onset and Death
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								23f. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other							
				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 20, 2006</b>					
State Registrar		30. Name and address of person who completed cause of death (Item 23a) <b>Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>		31. Date filed (Month, Day, Year) <b>SEP 22 2006</b>		32. Registrar's Signature <i>James A. Spangler</i>		ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30706

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

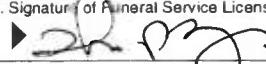
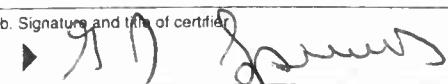
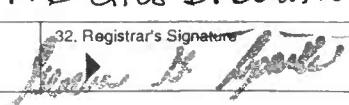
1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death
<b>DAVID ZIEGLER</b>		09 08 2006 3:05 PM				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death
<b>LORIEN NURSING &amp; REHABILITATION</b>		<b>BALTIMORE</b>				<b>BALTIMORE</b>
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 29, 1928	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>
10a. State <b>MARYLAND</b>		10b. County <b>CECIL</b>		10c. City, Town or Location <b>ELKTON</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>125 EVAN DRIVE</b>			10f. Zip Code <b>21921</b>			10g. Citizen of What Country? <b>AMERICA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1947-1988</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>WELDER-MAINTENANCE</b>		16b. Kind of Business/Industry <b>MANUFACTURING</b>		
17. Father's Name (First, Middle, Last) <b>GEORGE J. ZIEGLER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>NETTIE GREET</b>		
19a. Informant's Name/Relationship (Type, Print) <b>SANDRA K. JENKINS-DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>125 EVAN DR. ELKTON, MARYLAND 21921</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>ODD FELLOWS CEMETERY</i>		20b. Place of Disposition (Name of other place) <b>ODD FELLOWS CEMETERY</b>		Date <b>9/15/06</b>	20c. Location - City or Town, State <b>LAUREL, DELAWARE</b>	
21. Signature of Funeral Service Licensee <i>Taylor Yates</i>		22. Name and Address of Facility <b>WATSON-YATES FUNERAL HOME, INC.</b> <b>SEAFORD, DE LAWARE 19973</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>BRAIN CA</b>						
Approximate Interval Between Onset and Death						
a. Due to (or as a consequence of): <b>ICH</b>						
b. Due to (or as a consequence of):						
c. Due to (or as a consequence of):						
d. _____						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____				
27. Manner of Death Natural <input checked="" type="checkbox"/> Pending investigation Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>Hir, MD</i>				29c. License number <b>DS7727</b>		29d. Date signed (Month, Day, Year) <b>9/11/06</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Narenler Banerji &amp; Market Place - Dundalk MD 21222</b>						
31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>		32. Registrar's Signature <i>Renee B. Farak</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 5, 7, 8, 9, PFR FH G860, 10/4/06 WS

1- For Amend #20c per FH G859 9/28/06 JH  
State of Maryland, Department of Health and Mental Hygiene  
Certificate of Death

2006 30707  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mildred E. Alberts</b>								2. Date of Death Month Day Year <b>Sept 25, 2006</b>	3. Time of Death 14:40 M
	4a. Facility Name (If not institution, give street and number) <b>Spa Creek Meridian Nursing Home</b>				4b. City, Town, or Location of Death <b>Annapolis</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>296-05-9252</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> <input checked="" type="checkbox"/> Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>06/29/1916</b>	9. Birthplace (State or Foreign Country) <b>OH</b> <input checked="" type="checkbox"/>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Edgewater</b>								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>70 Tarragon Lane</b>				10f. Zip Code <b>21037</b>				10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>				16b. Kind of Business/Industry <b>Education</b>	
	17. Father's Name (First, Middle, Last) <b>Silas Burton</b>								18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Brooks</b>	
	19a. Informant's Name/Relationship (Type, Print) <b>Charlene Brogan/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>70 Tarragon Lane Edgewater, MD 21037</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Riverside Cemetery</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverside Cemetery</b>				Date <b>Sept 30, 2006</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Charles L. Stevens Funeral Home Inc.</b> <b>1501 East Fort Ave Baltimore MD 21230</b>				20c. Location - City or Town, State <b>Monroeville, OH</b>	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Achalasia</b>								Approximate Interval Between Onset and Death	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GARY SPROUSE MD 2108 DIDONATO DR, CHESTER MD 21619</b>								29c. License number <b>532036</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>								32. Registrar's Signature 	

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importantly: If Item 27 is marked other than "natural", or Items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30708  
Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stanley Alseth</b>							2. Date of Death Month Day Year <b>SEPTEMBER 17, 2006</b>			3. Time of Death <b>9:43 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>							4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>469-12-4882</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>90 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Hours <b>0</b>	8. Date of Birth (Month Day, Year) <b>May 7, 1916</b>	9. Birthplace (State or Foreign Country) <b>Montana</b>					
	10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>					10d. Inside City Limits <b>Yes</b>			
To Be Completed by Funeral Director	10e. Street and Number <b>800 Southerly Road</b>				10f. Zip Code <b>21286</b>			10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <b>Married</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>No</b>			14. Race - American Indian, Black, White, etc. <b>white</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>		16b. Kind of Business/Industry <b>public health</b>								
	17. Father's Name (First, Middle, Last) <b>Stengrim Alseth</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Olivia Strom</b>										
	19a. Informant's Name/Relationship (Type, Print) <b>St. Joseph Med Ctr</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7601 Osler Drive Towson, MD 21204</b>										
	20a. Method of Disposition <b>Burial</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>		Date			20c. Location - City or Town, State					
	21. Signature + Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Approximate Interval Between Onset and Death <b>days</b>								
	{		a. Due to (or as a consequence of): <b>ASPIRATION PNEUMONIA</b>										
	{		b. Due to (or as a consequence of):										
	{		c. Due to (or as a consequence of):										
	{		d. _____										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>Yes</b>		23c. If yes, outcome of pregnancy <b>Live birth</b>		23d. Date of delivery Month Day Year								
	9 Unknown		4 Pregnant at time of death 9 Unknown		3 Ectopic pregnancy 5 Other (specify) _____								
	23e. Did tobacco use contribute to the cause of death? <b>No</b>												
	24a. Was an autopsy performed? <b>Yes</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>No</b>										
	25. Was case referred to medical examiner? <b>No</b>		26. Place of Death (Check only one) Hospital: <b>Inpatient</b> ER/Outpatient DOA Other: Nursing Home Residence Other (Specify)										
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred				
	5 Pending investigation 6 Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <b>Medical Examiner</b>		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier <b>Lilia Ceballos, M.D.</b>		29c. License number <b>D25886</b>		29d. Date signed (Month, Day, Year) <b>Sep. 18 - 2006</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LILIA CEBALLOS, M.D. F.A.C.E. 7601 OSLER DRIVE TOWSON MARYLAND 21204</b>												
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Jessica B. Acosta</b>										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Baby A Atkins</b>						2. Date of Death Month <b>08</b> Day <b>17</b> Year <b>2006</b>	3. Time of Death <b>1940</b>	
Funeral Director	4a Facility Name (If not institution, give street and number) <b>University of Maryland</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore city</b>		
To Be Completed by Funeral Director	5. Social Security Number <b>NONE</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>2</b>	If Under 1 Year Months <b>37</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>2</b> Min. <b>37</b>	8. Date of Birth (Month, Day, Year) <b>8/17/2006</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	10a. State <b>MD</b>		10b. County <b>Cecil</b>	10c. City, Town or Location <b>Elkton</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>123 Elk Chase Drive</b>				10f. Zip Code <b>21921</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>none</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>black</b>		14. Race - American Indian, Black, White, etc. Specify:		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) none</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) none</b>		16b. Kind of Business/Industry <b>none</b>				
	17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Desire Atkins</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Desire Atkins/mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>123 Elk Chase Dr. Elkton, MD 21921</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>								
	22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Approximate Interval Between Onset and Death								
	Immediate Cause (Final disease or condition resulting in death) <b>a. Preterm delivery at 22 weeks</b> Due to (or as a consequence of): <b>2h 37m</b>								
	b. _____ Due to (or as a consequence of):								
	c. _____ Due to (or as a consequence of):								
	d. _____								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide      4 <input type="checkbox"/> Homicide</b>								
	28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>								
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	28d. Describe how injury occurred								
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>								
	29b. Signature and title of certifier <b>J Jennifer Scanlon MD</b>								
	29c. License number <b>17342</b>								
	29d. Date signed (Month, Day, Year) <b>08/17/2006</b>								
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jennifer Scanlon 22 S. Greene St. Baltimore, MD 21201</b>								
	31. Date filed (Month, Day, Year) <b>AUG 29 2006</b>								
	32. Registrar's Signature <b>J Jennifer Scanlon</b>								

2006 30710  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Baby Boy B Atkins</b>							2. Date of Death Month Day Year <b>08 17 2006</b>	3. Time of Death <b>1940</b>				
	4a. Facility Name (if not institution, give street and number) <b>University of Maryland</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>Baltimore City</b>						
Funeral Director	5. Social Security Number <b>none</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) Yrs. <b>1</b>	If Under 1 Year Months <b>1</b>	If Under 24 Hrs. Hours <b>34</b>	8. Date of Birth (Month, Day, Year) <b>8/17/2006</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>						
Usual Residence of Decedent													
10a. State <b>MD</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>					10d. Inside City Limits <b>1 Yes 2 No</b>				
10e. Street and Number <b>123 Elk Chase Drive</b>				10f. Zip Code <b>21921</b>				10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates: <b>none</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify:					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) none</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>none</b>				16b. Kind of Business/Industry <b>none</b>					
17. Father's Name (First, Middle, Last) <b>unk</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Desire Atkins</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Desire Atkins/mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>123 Elk Chase Dr. Elkton, MD 21921</b>									
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
Approximate Interval Between Onset and Death													
Immediate Cause (Final disease or condition resulting in death)													
a. <b>Preterm delivery at 22 weeks 1h 34m</b>													
Due to (or as a consequence of):													
{ b. _____ Due to (or as a consequence of):													
c. _____ Due to (or as a consequence of):													
d. _____													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>													
24a. Was an autopsy performed? <b>1 Yes 2 No</b>													
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>													
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>											
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred					
5 Pending investigation 6 Could not be determined		M											
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>													
29b. Signature and title of certifier <b>Jennifer Scanlon MD</b>		29c. License number <b>17342</b>				29d. Date signed (Month, Day, Year) <b>8/17/2006</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jennifer Scanlon 22 S. Greene St. Baltimore, MD 21201</b>													
31. Date filed (Month, Day, Year) <b>AUG 29 2006</b>		32. Registrar's Signature <b>Debra B. Jones</b>											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30711  
Reg. No.

1- For  
State  
Registrar

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last)							2. Date of Death	3. Time of Death	
	RONALD BISAILLOW							Month SEP	Day 22	Year 2006
<b>Funeral Director</b>	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
	LAUREL REGIONAL HOSPITAL			LAUREL			PRINCE GEORGE			
<b>To Be Completed by Funeral Director</b>	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) May 15, 1960	9. Birthplace (State or Foreign Country) Illinois		
	355-58-1365									
Usual Residence of Decedent										
10a. State DC		10b. County District of		10c. City, Town or Location Washington						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 4813 Bladen Ave.				10f. Zip Code 20011				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: American Indian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Administrator			16b. Kind of Business/Industry Credit Union					
17. Father's Name (First, Middle, Last) Unknown					18. Mother's Name (First, Middle, Maiden Surname) Unknown					
19a. Informant's Name/Relationship (Type, Print) William C. Frey, P.O.A.					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Spring Street Silver Spring, MD 20910					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory			20c. Location - City or Town, State Sep. 28, 06 Baltimore, MD		
21. Signature of Funeral Service Person Kim MacLeod										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) SEPSIS										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. MACT CREMATOR c. PNEUMONIA										
Approximate Interval Between Onset and Death 3 DAYS 10 DAYS 3 WEEKS										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HOSPITALIZING FOR WORK HUMAN IMMUNODEFICIENCY SYNDROME										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 036974					29d. Date signed (Month, Day, Year) SEP 22 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID O. NYANJOM MD 10724 LITTLE PATRIOTIC DRIVE COLUMBIA MD 21044										
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature David O. Nyangom								

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, *W*

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10e, 19b per th g860 10-6-06 vt

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2006 30712

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		JUSTINE E. BITZ		2. Date of Death Month Day Year	3. Time of Death 7:35 PM
4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>213-26-7621</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
				8. Date of Birth Month Day Year <b>11-12-1928</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>SPARKS</b>		
10e. Street and Number <b>14210 DOVE CREEK WAY, UNIT 204</b>		10f. Zip Code <b>21052 21152</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 YEARS</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
17. Father's Name (First, Middle, Last) <b>FREDERICK HENRY LIMPERT</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ELSIE PRECHTEL</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MILTON D. BITZ (HUSBAND)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14210 DOVE CREEK WAY, SPARKS, MARYLAND, 21052 21152</b>		20c. Location - City or Town, State <b>TOWSON, MARYLAND, 21204</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>HILLTOP SERVICE CORP.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HILLTOP SERVICE CORP.</b>		Date <b>09-27-2006</b>	
21. Signature of Funeral Service Licensee <b>R. G. RUTH</b>		22. Name and Address of Facility <b>RUCK TOWSON FUNERAL HOME, INC.</b>		1050 YORK ROAD <b>TOWSON, MD. 21204</b>	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. <b>SEPTIC SHOCK</b> Due to (or as a consequence of): <b>ACUTE PERITONITIS</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. <b>PERFORATED INTRA-ABDOMINAL VISCUS</b> Due to (or as a consequence of):</p> <p>d. _____</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>M</b> 28b. Time of Injury <b>M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D 0017695</b>		29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ABDALLAH J. HELOU, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204</b>					
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <i>[Signature]</i>			

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30713

1- For State  
Registrar**Physician/  
Medical Examiner**

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>VALJUAN ANDRE BROWN</b>					2. Date of Death Month Day Year <b>September 22, 2006</b>		3. Time of Death 1739 hrs		
		4a. Facility Name (if not institution, give street and number) <b>Sinai Hospital</b>					4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director		5. Social Security Number <b>217-66-6406</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>49</b>	Yrs.	If Under 1 Year Months <b>03</b>	If Under 24 Hrs. Days <b>02</b>	8. Date of Birth (MM/DD/YYYY) <b>03.02.1957</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
		Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>COLUMBIA</b>			10d. Inside City Limits <b>1 Yes 2 No</b>
To Be Completed by Funeral Director		10e. Street and Number <b>5231 LIGHTNING VIEW</b>				10f. Zip Code <b>21045</b>			10g. Citizen of What Country? <b>USA</b>		
		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: <b>BLACK</b>			14. Race - American Indian, Black, White, etc.
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>2 YRS</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CARPENTRY</b>			16b. Kind of Business/Industry <b>HOME IMPROVEMENT</b>		
		17. Father's Name (First, Middle, Last) <b>JOHN E. BROWN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BETTY DAUGHERTY</b>					
Physician /Medical Examiner		19a. Informant's Name/Relationship (Type, Print) <b>BETTY HOLLINGSWORTH (MOTHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5237 LIGHTNING VIEW, COLUMBIA, MD 21045</b>					
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <b>Vaughn C. Greene Funeral Service</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>			Date <b>10.02.06</b>	20c. Location - City or Town, State <b>OWINGS MILLS, MD</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>Vaughn C. Greene</b>				22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD 21229</b>					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last							Approximate Interval Between Onset and Death		
<p>a. <b>Multiple Injuries</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> <p><input type="checkbox"/> UNPENDED      <input type="checkbox"/> AMENDED</p>											
Medical Certification: To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth      2 <input type="checkbox"/> Fetal death      3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death      5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA      Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other							
		27. Manner of Death 1 <input type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide      4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Sep 7, 2006</b>		28b. Time of Injury <b>1755 hrs</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Pedestrian struck by auto</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Local Street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>4600 Blk Liberty Heights Ave, Baltimore, MD</b>					
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar		29b. Signature and title of certifier <b>Margarita Krell</b>				29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>September 23, 2006</b>		
		30. Name and address of person who completed cause of death (Item 23a) <b>Margarita Krell MD. Assistant Medical Examiner</b>				31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature <b>Leanne B. Spauls</b>		

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30714

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Craig Steven Bush</b>							2. Date of Death Month Day Year <b>September 24, 2006</b>	3. Time of Death <b>8:00 a.m.</b>										
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Center</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>												
Funeral Director	5. Social Security Number <b>220-80-2398</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>47 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>May 20, 1959</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>										
Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Joppa</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
10e. Street and Number <b>586B Renee Drive</b>				10f. Zip Code <b>21085</b>			10g. Citizen of What Country? <b>U.S.A.</b>												
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Elementary/Secondary (0-12)</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>self-employed</b>			14. Race - American Indian, Black, White, etc. <b>Specify: white</b>											
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>2</b>			16b. Kind of Business/Industry <b>flower business</b>														
17. Father's Name (First, Middle, Last) <b>Carroll Bush</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Kelly Bush/brother Carmella Campisi</b>														
19a. Informant's Name/Relationship (Type, Print) <b>Kelly Bush/brother</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>586B Renee Drive, Joppa, Md. 21085</b>														
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>[Signature]</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>			Date <b>9/28/06</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>												
21a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying Cause (Final disease or condition resulting in death) <b>Glioblastoma Multiform</b> Approximate Interval Between Onset and Death <b>5 years</b>																			
21b. Sequential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>																			
22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc.</b> <b>610 W. MacPhail Road, Bel Air, Md. 21014</b>																			
23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying Cause (Final disease or condition resulting in death) <b>Glioblastoma Multiform</b> Approximate Interval Between Onset and Death <b>5 years</b>		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <b>Helen M. Gordon</b>					29c. License number <b>D0051926</b>			29d. Date signed (Month, Day, Year) <b>September 24, 2006</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen M. Gordon 6565 N. Charles St, Baltimore MD 21204</b>					31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>					32. Registrar's Signature <b>[Signature]</b>									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

## Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

<b>Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.</b> <small>amend items 10e, 19b per th g859 9-28-06 vt State of Maryland / Department of Health and Mental Hygiene amend item 10e per dvr g860 10-3-06 vt Certificate of Death</small>											
<b>2006 30715</b> <small>Reg. No.</small>											
<b>Physician /Medical Examiner</b>  <b>For State Registrar</b>		<b>1. Decedent's Name (First, Middle, Last)</b> <i>Ernestine . Bushinger</i> <b>4a. Facility Name (If not institution, give street and number)</b> <i>Catered Living - Cockeysville</i> <b>5. Social Security Number</b> <i>218-01-0796</i>									
<b>Funeral Director</b>  <b>To Be Completed by Funeral Director</b>		<b>2. Date of Death</b> <small>Month Day Year</small> <i>Sept. 26 2006</i> <b>3. Time of Death</b> <i>9:10 P M</i>									
		<b>4b. City, Town, or Location of Death</b> <i>Cockeysville</i> <b>4c. County of Death</b> <i>Baltimore</i>									
		<b>4. Facility Name (If not institution, give street and number)</b> <i>Catered Living - Cockeysville</i> <b>5. Social Security Number</b> <i>218-01-0796</i>									
		<b>6. Sex</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F <b>7. Age (In yrs. last birthday)</b> <i>92 Yrs.</i>									
		<b>8. Date of Birth</b> <small>(Month, Day, Year)</small> <i>Dec. 19 1913</i>									
		<b>9. Birthplace (State or Foreign Country)</b> <i>MD</i>									
		<b>10a. State</b> <b>10b. County</b> <b>10c. City, Town or Location</b> <i>MD Baltimore Cockeysville</i>									
		<b>10d. Inside City Limits</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		<b>10e. Address Number</b> <i>10707</i> <b>10f. Street Name</b> <i>10707 Tyrie Ave.</i> <b>10g. Citizen of What Country?</b> <i>USA</i>									
		<b>11. Marital Status</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <b>12. Was Decedent Ever in U.S. Armed Forces?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>If Yes, Give Year or Dates:</small>									
		<b>13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>Specify:</small>									
		<b>14. Race - American Indian, Black, White, etc.</b> <small>Specify:</small> <i>white</i>									
		<b>15. Decedent's Education (Specify only highest grade completed)</b> <small>Elementary/Secondary (0-12) College (1-4 or 5+)</small> <i>11 n/a</i>									
		<b>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)</b> <i>Office Administrator</i>									
		<b>16b. Kind of Business/Industry</b> <i>Monuments</i>									
		<b>17. Father's Name (First, Middle, Last)</b> <i>George Walter Tyrie</i>									
		<b>18. Mother's Name (First, Middle, Maiden Surname)</b> <i>Charlotte Zink</i>									
		<b>19a. Informant's Name/Relationship (Type, Print)</b> <i>John Tyrie Barshinger/Son</i> <b>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)</b> <i>10706 10707 Tyrie Ave., Cockeysville, MD 21030</i>									
		<b>20a. Method of Disposition</b> <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>20b. Place of Disposition (Name of cemetery, crematory or other place)</b> <i>Metro Crematory</i>									
		<b>Date</b> <i>9/27/06</i>									
		<b>20c. Location - City or Town, State</b> <i>Catonsville, MD</i>									
		<b>21. Signature of Funeral Service Licensee</b> <i>Bryan W. Clary</i>									
		<b>22. Name and Address of Facility</b> <i>Lemmon Funeral Home of Dulaney Valley, Inc.</i> <b>10 W. Padonia Rd., Timonium, MD 21093</b>									
		<b>23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</b> <small>Immediate Cause (Final disease or condition resulting in death)</small> <i>Subacute cerebral accident</i>									
		<b>Approximate Interval Between Onset and Death</b>									
		<b>23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</b> <small>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</small> <i>a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):</i>									
		<b>23d. Date of delivery</b> <small>Month Day Year</small>									
		<b>23e. Did tobacco use contribute to the cause of death?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
		<b>24a. Was an autopsy performed?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		<b>24b. Were autopsy findings available prior to completion of cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		<b>25. Was case referred to medical examiner?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		<b>26. Place of Death (Check only one)</b> <small>Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</small>									
		<b>27. Manner of Death</b> <small>1 □ Natural 5 □ Pending investigation    2 □ Accident 6 □ Could not be determined    3 □ Suicide 4 □ Homicide</small>									
		<b>28a. Date of Injury (Month, Day, Year)</b> <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <small>M 1 □ Yes 2 □ No</small>									
		<b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b>									
		<b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>									
		<b>29a. Certifier (Check only one)</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		<b>29b. Signature and title of certifier</b> <i>Todd Baldwin MD</i>									
		<b>29c. License number</b> <i>050592</i>									
		<b>29d. Date signed (Month, Day, Year)</b> <i>September 27, 2006</i>									
		<b>30. Name and address of person who completed cause of death (Item 23a) (Type, Print)</b> <i>Todd Baldwin - 10707 Falls Road Suite 225 Lutherville, Maryland</i>									
		<b>31. Date filed (Month, Day, Year)</b> <b>32. Registrar's Signature</b> <i>SEP 28 2006</i> <i>Todd Baldwin</i>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
1- For Amend Item 2 per Dr., G859, 09/28/06 dhb Certificate of Death 2006 30716  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kathleen Logan Boyd</b>						2. Date of Death <b>09/20/2006</b> Month <b>Sept.</b> Day <b>20</b> Year <b>2006</b>	3. Time of Death <b>4:30 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Pickersgill</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>220-34-5401</b>	6. Sex <b>1 □ M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>96 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>April 23 1910</b>	9. Birthplace (State or Foreign Country) <b>MA</b>		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b>				10c. City, Town or Location <b>Towson</b>			10d. Inside City Limits <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>615 Chestnut Ave.</b>			10f. Zip Code <b>21204</b>			10g. Citizen of What Country? <b>USA</b>		
Physician /Medical Examiner	11. Marital Status <b>1 □ Never Married 2 □ Married 3 <input checked="" type="checkbox"/> Widowed 4 □ Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates: <b>Year</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b> Specify: <b>white</b>	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>			16b. Kind of Business/Industry <b>Health Care</b>		
Baltimore, Maryland 21215-0036	17. Father's Name (First, Middle, Last) <b>Louis F. Leavy</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Logan</b>					
Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at this time.	19a. Informant's Name/Relationship (Type, Print) <b>Waller S. Boyd, Jr./Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1811 Landrake Rd., Towson, MD 21204</b>					
	20a. Method of Disposition <b>X <input checked="" type="checkbox"/> Burial 2 □ Cremation 3 □ Removal from State 4 <input checked="" type="checkbox"/> Donation 5 □ Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Mausoleum</b>			Date <b>9/22/06</b>	20c. Location - City or Town, State <b>Pikesville, MD</b>	
	21. Signature of Funeral Service Licensee <b>Lowell M. Lemmon</b>			22. Name and Address of Facility <b>lemon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Severe obstructive lung disease</b>						Approximate Interval Between Onset and Death <b>year</b>		
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. If yes, outcome of pregnancy <b>1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown</b>			23d. Date of delivery Month Day Year		
	23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No 3 □ Probably 4 □ Unknown</b>			23f. Was an autopsy performed? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>			23g. Were autopsy findings available prior to completion of cause of death? <b>1 □ Yes 2 □ No</b>		
	25. Was case referred to medical examiner? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>			26. Place of Death (Check only one) Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 □ Residence 6 □ Other (Specify)</b>			27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 □ Accident 3 □ Suicide 4 □ Homicide</b> 5 □ Pending investigation 6 □ Could not be determined		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <b>1 □ Yes 2 □ No</b> 28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>W.A.Riley 6701 N. Charles St. Balt. MD 21208</b>					
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>			29c. License number <b>D25205</b>			29d. Date signed (Month, Day, Year) <b>September 20, 2006</b>		
	29b. Signature and title of certifier <b>W.A.Riley, MD</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A.Riley 6701 N. Charles St. Balt. MD 21208</b>			31. Date filed (Month, Day, Year) <b>SEP 21 2006</b> 32. Registrar's Signature <b>John S. [Signature]</b>		

Please Type or Print in Black Indelible Ink  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2006 30717

1- For State Registrar

Physician/  
Medical ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

1. Decedent's Name (First, Middle, Last) <i>Craig Biggs</i>		2. Date of Death Month Day Year August 4, 2006		3. Time of Death 1103 hrs
4a. Facility Name (if not institution, give street and number) Franklin Square Hospital		4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore County
5. Social Security Number <i>216-82-4744</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>34</i> Yrs.	If Under 1 Year Months Days Hours Min If Under 24 Hrs. Sept 19, 1972
8. Date of Birth (MM/DD/YYYY) <i>Sept 19, 1972</i>		9. Birthplace (State or Foreign Country) <i>MD</i>		
10a. State <i>MD</i>		10b. County <i>Baltimore</i>	10c. City, Town or Location <i>Rose Dale</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <i>5124 BRIGHT LEAF CT</i>		10f. Zip Code <i>21237</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify	
14. Race - American Indian, Black, White, etc <i>White</i>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Never Worked</i>	16b. Kind of Business/Industry <i>N/A</i>	
17. Father's Name (First, Middle, Last) <i>Edward Biggs Sr</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Catherine Miller</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Catherine Rebbert</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5124 BRIGHT LEAF CT BATH MD 21237</i>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other Specify <i>Entombment</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Prospect Hill Cem</i>	Date <i>8-9-06</i>	20c. Location - City or Town, State <i>Towson Md</i>
21. Signature of Funeral Service Licensee <i>Paul M. Stella</i>		22. Name and Address of Facility Paul Stella Funeral Home <i>7527 Harford Rd. Baltimore, MD 21234</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line a. <b>Seizure Disorder</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
Approximate Interval Between Onset and Death				
X UNPENDED		<input type="checkbox"/> AMENDED item#23a,27,perME,g860, 10/2/06 TT		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29b. Signature and title of certifier <i>Mary G. Ripple MD.</i>		
		29c. License number <i>O.C.M.E.</i>		29d. Date signed (Month, Day, Year) <i>August 5, 2006</i>
30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner		111 Penn Street, Baltimore, MD 21201		
31. Date filed (Month, Day, Year) <i>SEP 28 2006</i>		Registrar's Signature <i>James A. Parker</i>		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30718

1- For  
State  
Register

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)	Alvin B. Bridner, Jr.				2. Date of Death Month Sept Day 25 Year 2006	3. Time of Death 10:42 AM	
4a. Facility Name (If not institution, give street and number) SAINT AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death Baltimore City	
5. Social Security Number 216-20-7892	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) October 24, 1926	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore				10c. City, Town or Location Catonsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 711 Raynor Ave.				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1		16b. Kind of Business/Industry Plant Manager		Managerial / Printing Press	
17. Father's Name (First, Middle, Last) Alvin B. Bridner				18. Mother's Name (First, Middle, Maiden Surname) Leona mahaffay			
19a. Informant's Name/Relationship (Type, Print) Mrs. June Bridner Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Raynor Ave. Catonsville, Maryland 21228			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial Gardens		Date 09/28/2006	20c. Location - City or Town, State Marriottsville, Maryland		
21. Signature of Funeral Service Licensee Melody M. Bridner				22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): LUNG CANCER</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>							
Approximate Interval Between Onset and Death - 5 YEARS							
5 YEARS							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Muhammad Saim, M.D.		29c. License number P-18613.		29d. Date signed (Month, Day, Year) SEPT, 25, 2006.			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammad SAIM, 900 S-CATON AVE, BALTIMORE, MD - 21229.							
31. Date filed (Month, Day, Year) SEP, 28 2006		32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

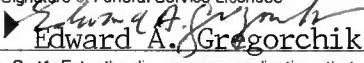
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30719

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Virginia Cole</b>							2. Date of Death Month Day Year <b>September 25, 2006</b>	3. Time of Death P.M. <b>7:15 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Chapel Hill Nursing Center</b>			4b. City, Town, or Location of Death <b>Randallstown</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>219-20-9214</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>FEB 19, 1919</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>4511 Robosson Road</b>				10f. Zip Code <b>21133</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>21</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>	16b. Kind of Business/Industry <b>Food Service</b>
17. Father's Name (First, Middle, Last) <b>Thomas Braizer</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Etta M. Peterson</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Virginia A. Marzullo/Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1336 Challenger Avenue, Davenport, FL 33897</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Edward A. Gregorchik</b>					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		Date <b>9/26/06</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Cremation Society of MD, Inc.</b> <b>299 Frederick Road Baltimore, MD 21228</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death
	<p>a. <i>Atherosclerotic heart disease</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number <b>D47683</b>				29d. Date signed (Month, Day, Year) <b>September 26, 2006</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Raymond Miller 25 Main Street Suite 200 Randallstown, MD 21136</b>									
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30720

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Lee Coppie</b>							2. Date of Death Month <b>September</b> Day <b>14<sup>th</sup></b> Year <b>2006</b>		3. Time of Death <b>12:26 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital of Baltimore</b>							4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>Connecticut</b>
Funeral Director	5. Social Security Number <b>288-22-5693</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	II Under 1 Year Months	II Under 24 Hrs. Days	III Under 24 Hrs. Hours	IV Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year) <b>Feb 1, 1929</b>	9. Birthplace (State or Foreign Country) <b>Connecticut</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Lutherville</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>6 Nightingale Way</b>				10f. Zip Code <b>21093</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>'51-53</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- II Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 4 stockbroker</b>		16b. Kind of Business/Industry <b>financial</b>					
	17. Father's Name (First, Middle, Last) <b>John Lee Coppie Sr</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Marion Peck</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Charles Robson/friend</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Nightingale Way Lutherville, MD 21093</b>				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Ronald S. Wade, Director</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date			20c. Location - City or Town, State <b>Baltimore, MD 21201</b>		
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Complications of Diabetes Mellitus</b> Due to (or as a consequence of): <b>Atherosclerotic Heart Disease</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____									
	23b. If female: 23c. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D 0056388</b>					29d. Date signed (Month, Day, Year) <b>September 14<sup>th</sup>, 2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Chandish Slight, MD Sinai Hospital of Baltimore</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>James B. Appling</b>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30721

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death				
<b>Shirley B. Clemens</b>	<b>September 25, 2006</b>				<b>2:00 PM</b>				
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				4c. County of Death				
<b>Oac Crest Village</b>	<b>Parkville</b>				<b>Baltimore</b>				
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug. 26, 1920</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>			
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Parkville</b>				10g. Citizen of What Country? <b>USA</b>			
10e. Street and Number <b>8820 Walther Blvd.</b>			10f. Zip Code <b>21234</b>			14. Race - American Indian, Black, White, etc. <b>White</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Arthur Bunce</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Sticht</b>			19a. Informant's Name/Relationship (Type, Print) <b>Andrew C. Clemens/Son</b>			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1819 Dunwoody Road, Baltimore, Maryland 21234</b>			20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Metro Crematory</b>			Date <b>9/28/06</b>	20c. Location - City or Town, State <b>Catonsville, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Bryan W. Clary</b>			22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093</b>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death			
a. <b>ASCV</b> Due to (or as a consequence of):									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b> <b>Atrial fibrillation</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier <b>An Monias</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anne Monias 8800 Walther Boulevard Parkville, MD 21234</b>						29c. License number <b>DSR 646</b>			
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>						29d. Date signed (Month, Day, Year) <b>September 26, 2006</b>			
32. Registrar's Signature <b>Leanne B. Agate</b>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30722

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jairo Damian Casanoba</b>							2. Date of Death Month Day Year <b>September 25 2006</b>	3. Time of Death 4:09AM	
	4a. Facility Name (If not institution, give street and number) <b>National Institutes of Health</b>			4b. City, Town, or Location of Death <b>Bethesda</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>Unk</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>17 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>June 6, 1989</b>	9. Birthplace (State or Foreign Country) <b>Ecuador</b>	
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Silver Spring</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number <b>4206 Ferrara Dr.</b>				10f. Zip Code <b>20906</b>			10g. Citizen of What Country? <b>Ecuador</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Ecuadorian</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Hispanic</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>			16b. Kind of Business/Industry <b>None</b>			
17. Father's Name (First, Middle, Last) <b>Franklin Casanoba</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mariana Sanchez</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Jessica Casanoba/Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4206 Ferrara Dr. Silver Spring, Md. 20906</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>J. P. Marshall</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>			Date <b>9-27-2006</b>	20c. Location - City or Town, State <b>Alexandria, VA.</b>		
21. Signature of Funeral Service Licensee <b>J. P. Marshall</b>				22. Name and Address of Facility <b>Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Acute Lymphoblastic Leukemia</b> Approximate Interval Between Onset and Death <b>13 years</b>										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		
		28a. Date of Injury (Month, Day Year) <b>September 25 2006</b>			28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b> 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>MD424012</b>						29d. Date signed (Month, Day, Year) <b>9/25/06</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Meredith Chuk</b> 10 Center Drive, Bethesda, Maryland 20892										
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>John S. [Signature]</b>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2006 30723

1- For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Ana Constandaky</b>						2. Date of Death Month Day September 19, 2006	3. Time of Death 9:00 a.m.
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) <b>5035 Green Mountain Circle</b>			4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>		
Funeral Director		5. Social Security Number <b>4107-58-8888</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>97 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 20, 1909</b>	9. Birthplace (State or Foreign Country) <b>Romania</b>	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Howard</b> 10c. City, Town or Location <b>Columbia</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>5035 Green Mountain Circle</b>			10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
		17. Father's Name (First, Middle, Last) <b>Dumitru Bragadir</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Florica Eremie-Popa</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Mr. Serban Constandaky Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5035 Green Mountain Circle Columbia, Maryland 21044</b>					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Columbia Memorial Park</b>		Date <b>09/23/2006</b>	20c. Location - City or Town, State <b>Clarksville, Maryland</b>		
		21. Signature of Funeral Service Licensee <b>Melody Belk-Bright mar293</b>		22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>					
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CARCINOMA OF THE ESCAPITAGUS</b>						Approximate Interval Between Onset and Death <b>3 MONTHS</b>	
		{ a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. _____							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A. Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and title of certifier <b>SCOTT MAULER MD</b>		29c. License number <b>D29909</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 20, 2006</b>		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SCOTT MAULER MD 2465 ROUTE 97 SUITE 10 GLENWOOD MO 2738</b>							
		31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Rebecca J. Jones</b>					

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or Item 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30724

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Albert Davis</i>				2. Date of Death Month Day Year <i>September 24 2006 12:42 M</i>	3. Time of Death		
	4a. Facility Name (If not institution, give street and number) <i>The Johns Hopkins Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore City</i>	4c. County of Death N/A				
Funeral Director	5. Social Security Number <i>212-26-5114</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>75 Yrs.</i>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <i>Sep 14, 1931</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>Maryland</i> 10b. County <i>N/A</i> 10c. City, Town or Location <i>Baltimore</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>1401 North Lakewood</i>			10f. Zip Code <i>21213</i>	10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1950 1952</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>Domestic Engineer</i>	16b. Kind of Business/Industry <i>Jewish Community Center</i>					
	17. Father's Name (First, Middle, Last) <i>Jack Davis</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Jessie Davis</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Deborah Green Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4309 Nicholas Avenue Baltimore, Maryland 21206</i>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Garrison Forest Veterans Cemetery</i>		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date <i>10/03/06</i>	20c. Location - City or Town, State <i>Owings Mills, Md.</i>			
	21. Signature of Funeral Service Licensee <i>Cecil A. Estep</i>		22. Name and Address of Facility <i>Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Lung Cancer</i>						Approximate Interval Between Onset and Death <i>3 months</i>	
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i> </i>							
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			<i> </i>	<i> </i>	<i> </i>	<i> </i>		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Yolanda Hendley</i>					
			29c. License number <i>Res-001</i>			29d. Date signed (Month, Day, Year) <i>September 26, 2006</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Yolanda Hendley, The Johns Hopkins Hospital 600 North Wolfe St Baltimore MD 21287</i>		31. Date filed (Month, Day, Year) <i>SEP 28 2006</i> 32. Registrar's Signature <i>James R. Frerichs</i>					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f below any injury or other traumatic event,  Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30725

**1- For State Registrar****Physician/  
Medical Examiner**

<b>Physician/ Medical Examiner</b>		1. Decedent's Name (First, Middle, Last) <b>Sarah M. Demarest</b>					2. Date of Death Month Day Year <b>September 24, 2006</b>	3. Time of Death 2152 hrs
		4a. Facility Name (if not institution, give street and number) <b>Suburban Hospital</b>			4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
<b>Funeral Director</b>		5. Social Security Number <b>218-98-3801</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>24</b>	If Under 1 Year Months Days Hours Min. Yrs.	8. Date of Birth (MM/DD/YYYY) <b>Jan. 28, 1982</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
		Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Olney</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>To Be Completed by Funeral Director</b>		10e. Street and Number <b>18813 Luray Court</b>			10f. Zip Code <b>20832</b>		10g. Citizen of What Country? <b>USA</b>	
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify	
<b>Physician /Medical Examiner</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>2</b>		16b. Kind of Business/Industry <b>Animal Adoption Coordinator</b>		
		17. Father's Name (First, Middle, Last) <b>James J. Demarest</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Bette L. Glaveskas</b>				
<b>To Be Completed by Physician/Medical Examiner</b>		19a. Informant's Name/Relationship (Type, Print) <b>Bette L. Demarest/Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18813 Luray Court Olney, MD 20832</b>				
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: <i>JM 8/3</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>Sept. 28, 2006</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>	
<b>Physician /Medical Examiner</b>		21. Signature of Funeral Service Licensee <i>JM 8/3</i>		22. Name and Address of Facility <b>Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore MD 21230</b>				
		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. <b>Diphenhydramine intoxication</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death
<b>Physician /Medical Examiner</b>		b. Due to (or as a consequence of):						
		c. Due to (or as a consequence of):						
<b>Physician /Medical Examiner</b>		d. Due to (or as a consequence of):						
<b>Physician /Medical Examiner</b>		<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	#23a, 27, 28a-f, per ME, g860 10/26/06 TT				
<b>Physician /Medical Examiner</b>		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
<b>Physician /Medical Examiner</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23f. Did alcohol contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
<b>Physician /Medical Examiner</b>		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other		23g. Did prescription drugs contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
<b>Physician /Medical Examiner</b>		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Fnd 9/24/2006</b>		28b. Time of Injury <b>Fnd 9:00 pm</b>		
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>		
<b>Physician /Medical Examiner</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>8600 Old Georgetown Rd. Bethesda, MD</b>				
<b>Physician /Medical Examiner</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>		
<b>State Registrar</b>		30. Name and address of person who completed cause of death (Item 23a) <b>Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>		32. Registrar's Signature <i>Bevan B. Foster</i>				
<b>State Registrar</b>		31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		33. Registrar's Signature <i>Bevan B. Foster</i>				

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30726

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important! If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 10:44PM
<i>Harold Benjamin Dove</i>		<i>September 20, 2006</i>		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Howard County General Hospital</i>		<i>Columbia</i>		<i>Howard</i>
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) October 25, 1917
218-09-3999				
Usual Residence of Decedent				
10a. State <b>Maryland</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Ellicott City</b>		
10e. Street and Number <b>8575 Horseshoe Rd.</b>		10f. Zip Code <b>21043</b>	10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Truck Driver</b>	16b. Kind of Business/Industry <b>Trucking</b>	
17. Father's Name (First, Middle, Last) <b>Fenmore Cooper Dove</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Viola Basford</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Dorothy Dove Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8575 Horseshoe Rd. Ellicott City, Maryland 21043</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Maryland Shepherd Cemetery</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Good Shepherd Cemetery</b>		Date <b>09/23/2006</b>	20c. Location - City or Town, State <b>Ellicott City, Maryland</b>
21. Signature of Funeral Service Licensee <i>Maryland Shepherd Cemetery</i>				
22. Name and Address of Facility <b>Slack Funeral Home P A 3871 Old Columbia Pike Ellicott City, MD 21043</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Acute Myocardial Infarction</b>				
Approximate Interval Between Onset and Death				
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): <b>Hypotension</b></p> <p>b. Due to (or as a consequence of): <b>Metabolic Acidosis</b></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b>				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <i>Kwaku Hayford M.D.</i>				
29c. License number <b>D0062108</b>				
29d. Date signed (Month, Day, Year) <b>September 20, 2006</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kwaku Hayford M.D., Howard County General Hospital</b>				
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <i>Mary B. Foster</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30727

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Fowlkes</b>							2. Date of Death Month 9 Day 24 Year 2006	3. Time of Death 1935p M		
	4a. Facility Name (If not institution, give street and number) <b>J.H.H.</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>NA</b>				
Funeral Director	5. Social Security Number <b>215-30-5371</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>1-16-1919</b>	9. Birthplace (State or Foreign Country) <b>N.C.</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Md.</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>1505 Luzerne Avenue</b>			10f. Zip Code <b>21213</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: Black</b>			14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Beautician</b>		16b. Kind of Business/Industry <b>Beauty Shop</b>						
	17. Father's Name (First, Middle, Last) <b>Samuel Edmonds</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lina Belle Hardy</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Freddia McCoy Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1505 N. Luzerne Ave., Baltimore, Md. 21213</b>			Date <b>9-30-06</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>12. Burial</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Cem.</b>								
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Joseph R. Walter Jr.</b>		22. Name and Address of Facility <b>March F.H. East 1101 E. North Ave., Baltimore, Md. 21202</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>myocardial infarction, immediate hypertension</b>								Approximate Interval Between Onset and Death		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>										
	a. Due to (or as a consequence of): <b>myocardial infarction, immediate hypertension</b>										
	b. Due to (or as a consequence of): <b>hypertension</b>										
	c. Due to (or as a consequence of): <b></b>										
	d. <b></b>										
	t/F FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier <b>Rodney Brooks, MD</b>		29c. License number <b>04363C</b>			29d. Date signed (Month, Day, Year) <b>September 27, 2006</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rodney Brooks 3120 Erdman Avenue Baltimore Maryland</b>										
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Debbie A. Gandy</b>								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30728

Reg. No.

1- For  
State  
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Milton, A., Ferguson</i>							2. Date of Death Month Sept Day 24 Year 2006	3. Time of Death 1238 PM
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Center</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>N/A</i>		
Funeral Director	5. Social Security Number <i>218-36-3904</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>65 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>11/15/1940</i>	9. Birthplace (State or Foreign Country) <i>MD</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>N/A</i> 10c. City, Town or Location <i>Baltimore</i>							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>2516 W. Mosher St.</i>			10f. Zip Code <i>21217</i>			10g. Citizen of What Country? <i>U.S.A.</i>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Watchman</i>	16b. Kind of Business/Industry <i>City of Baltimore</i>						
	17. Father's Name (First, Middle, Last) <i>Nody Ferguson</i>	18. Mother's Name (First, Middle, Maiden Surname) <i>Roxianna Robinson</i>							
	19a. Informant's Name/Relationship (Type, Print) <i>Maxine Wintbush (Sister)</i>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2516 W. Mosher St. Baltimore, MD 21217</i>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Vaughn C. Greene</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Cemetery</i>	Date <i>9/29/2006</i>	20c. Location - City or Town, State <i>Baltimore, MD</i>					
	21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>	22. Name and Address of Facility <i>Vaughn C. Greene Funeral Svc 5151 Balto. N.H. Pike, Baltimore, MD 21229</i>							
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Myocardial Infarction</i>							Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <i>Myocardial Infarction</i>								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year	
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Robert S. Anderson, M.D.</i>	29c. License number <i>19650</i>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Robert S. Anderson Jr 2600 Ken Oak Rd Baltimore, Maryland 21215</i>	29d. Date signed (Month, Day, Year) <i>Sept. 24 2006</i>							
	31. Date filed (Month, Day, Year) <i>SEP 28 2006</i>	32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

**Division of Vital Records, P.O. Box 68760,**

**Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

**State of Maryland / Department of Health and Mental Hygiene**

**Amend Item 8 per th, G864, 02/15/07 dbb Certificate of Death**

Reg. No.

2006 30729

1 - For  
State  
Registrar

**Physician  
/Medical  
Examiner**

1. Decedent's Name (First, Middle, Last)	FORD			2. Date of Death Month Day Year	3. Time of Death
ADRIAN NEJEE				SEPTEMBER 17, 2006	1:10 P.M.
4a. Facility Name (If not institution, give street and number)	Clinton			4c. County of Death	
Southern Md Hospital				Prince George's	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 09/17/2006	9. Birthplace (State or Foreign Country) Maryland
none					

Funeral  
Director

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

10a. State MD	10b. County Charles	10c. City, Town or Location Indian Head	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 35 Riverside Run Drive		10f. Zip Code 20640	10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: black	14. Race - American Indian, Black, White, etc. Specify: black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) none	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) none	16b. Kind of Business/Industry none	
17. Father's Name (First, Middle, Last) Victor Ijoamh	18. Mother's Name (First, Middle, Maiden Surname) Jessica Ford		
19a. Informant's Name/Relationship (Type, Print) Southern MD Hospital	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Surratts Road Clinton, MD 20735		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
21. Signature of Funeral Service Licensee Ronald S. Wade, Director <i>Ronald S. Wade</i>	22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201		
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death		
a. <b>EXTREME PREMATURITY</b> Due to (or as a consequence of):			
b. <b>PREMATURE LABOR</b> Due to (or as a consequence of):			
c. _____ Due to (or as a consequence of):			
d. _____ Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28d. Describe how injury occurred	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number MD 46239		
29b. Signature and title of certifier <i>Bethesda, MD</i>	29d. Date signed (Month, Day, Year) 9/17/06		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRO ST. PATRICKS, DE WANDERL, MD 20603			
31. Date filed (Month, Day, Year) SEP 28 2006	32. Registrar's Signature <i>James L. Smith</i>		

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

2006 30730

1- For State  
Registrar

Reg. No.

**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director**

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23e or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial transit**1. Decedent's Name (First, Middle, Last)**

Peter Fouraris

**2. Date of Death**

Month Day Year

September 22, 2006

3. Time of Death

2200 hrs

**4a. Facility Name (if not institution, give street and number)**

11801 Rockville Pike

**4b. City, Town, or Location of Death**

Rockville

**4c. County of Death**

Montgomery

**5. Social Security Number**

099-48-3237

 M F**6. Sex**

50

Yrs.

**7. Age (In yrs. last birthday)****If Under 1 Year****If Under 24 Hrs.**

Months

Days

Hours

Min

June 8, 1956

**8. Date of Birth (MM/DD/YYYY)**

New York

**9. Birthplace (State or Foreign Country)****10a. State****10b. County**

Maryland Montgomery

**10c. City, Town or Location**

Rockville

**10d. Inside City Limits** Yes  No**10e. Street and Number**

11801 Rockville Pike #910

**10f. Zip Code**

20852

**10g. Citizen of What Country?**

United States

**11. Marital Status** Never Married  Married Widowed  Divorced**12. Was Decedent Ever in U.S. Armed Forces?** Yes  No

If Yes, Give Year or Dates:

**13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)** Yes  No specify:**14. Race - American Indian, Black, White, etc.**

Specify: White

**15. Decedent's Education (Specify only highest grade completed)**

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

**16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)**

Administrative Assistant

**16b. Kind of Business/Industry**

Federal Government

**17. Father's Name (First, Middle, Last)**

Jean Fouraris

**18. Mother's Name (First, Middle, Maiden Surname)**

Venerika Kondonaum

**19a. Informant's Name/Relationship (Type, Print)**

Athena Kranias/Sister

**19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)**

9005 Falls Chapel Way, Potomac, Maryland 20854

**20a. Method of Disposition** Burial  Cremation  Removal from State Donation  Other Specify**20b. Place of Disposition (Name of cemetery, crematory or other place)**

Parklawn Memorial Park

Date

Sept. 27,

2006

**20c. Location - City or Town, State**

Rockville, Maryland

**21. Signature of Funeral Service Licensee**

Ray Fouraris

**22. Name and Address of Facility**Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Ave., Rockville, MD 20850**23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.****Immediate Cause (Final disease or condition resulting in death)**

a. Cardiac arrhythmia

**Approximate Interval Between Onset and Death**

Due to (or as a consequence of):

b. Cardiomegaly associated with acute pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

#23a-b, PIT, 27, 28a-f, per ME g861.11/16/06 TT

**IF FEMALE:**

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No 9  Unknown**23c. If yes, outcome of pregnancy**1  Live birth 2  Fetal death 3  Ectopic pregnancy4  Pregnant at time of death 5  Other (Specify)9  Unknown**23d. Date of delivery**

Month Day Year

**Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

head injury

**23e. Did tobacco use contribute to the cause of death?**1  Yes 2  No 3  Probably 4  Unknown**25. Was case referred to medical examiner?**1  Yes 2  No**26. Place of Death (Check only one)**Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other: Scene**27. Manner of Death**1  Natural5  Pending Investigation2  Accident6  Could not be determined3  Suicide

(Specify) metro station

4  Homicide**28a. Date of Injury (Month, Day, Year)**

9/22/2006

**28b. Time of Injury**

6:50 am

**28c. Injury at Work?**1  Yes 2  No**28d. Describe how injury occurred**

subject fell

**28e. Place of Injury - At home, farm, street, factory, office building, etc.**

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1601 Rockville Pike

Rockville, MD

**29a. Certifier (Check only one)**1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated**29b. Signature and title of certifier**

Ling Li, MD

**29c. License number**

O.C.M.E.

**29d. Date signed (Month, Day, Year)**

September 23, 2006

**30. Name and address of person who completed cause of death (Item 23a)**

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

**31. Date filed (Month, Day, Year)**

SEP 28 2006

**32. Registrar's Signature**

Peter Fouraris

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30731

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NEIL A. FISHBONE</b>				2. Date of Death Month Day Year <b>Sept 25 2006</b>	3. Time of Death <b>3:28 P M</b>	
Funeral Director	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital of Baltimore</b>			4b. City, Town, or Location of Death <b>Baltimore City</b>	4c. County of Death <b>N/A</b>		
To Be Completed by Funeral Director	5. Social Security Number <b>218-50-6508</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52 Yrs.</b>	If Under 1 Year Months Days Hours Min. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	8. Date of Birth (Month Day Year) <b>07/08/1954</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
Usual Residence of Decedent							
10a. State <b>MD</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>203 OLD CROSSING DRIVE</b>			10f. Zip Code <b>21208</b>			10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1950</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <b>WHITE</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NONE</b>			16b. Kind of Business/Industry <b>NONE</b>	
17. Father's Name (First, Middle, Last) <b>IRVIN FISHBONE / FATHER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>RONNI GALPERIN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>IRVIN FISHBONE / FATHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 OLD CROSSING DRIVE - BALTIMORE, MD 21208</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>JAY CLAY</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH JACOB CEMETERY</b>	Date <b>09/27/2006</b>	20c. Location - City or Town, State <b>FINKSBURG, MD</b>	
21. Signature of Funeral Service Licensee <b>JAY CLAY</b>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>PNEUMONIA</b> Due to (or as a consequence of): <b>RIGHT SIDED EMPYEMA</b> Due to (or as a consequence of): <b>SEPSIS</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>15 days</b>
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hepatitis C</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Aruna Rokkam</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ARUNA ROKKAM, MD, Sinai Hospital of Baltimore</b>				29c. License number <b>Res 000</b>		29d. Date signed (Month, Day, Year) <b>Sept 25, 2006</b>	
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Debra K. Franks</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, ✓

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30732  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARTIN WILLIAM FURMAN</b>						2. Date of Death Month Day Year <b>SEPTEMBER 24 2006</b>	3. Time of Death <b>3:30 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOSPICE OF BALTIMORE GILCHRIST CTR.</b>			4b. City, Town, or Location of Death <b>TOWSON</b>			4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>218-26-6104</b>	6. Sex <b><input checked="" type="checkbox"/> M</b>	7. Age (In yrs. last birthday) <b>76 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>06/16/1930</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>BALTIMORE</b> 10c. City, Town or Location <b>BALTIMORE</b>								10d. Inside City Limits <b><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b>
	10e. Street and Number <b>12 POMONA SOUTH APT. 3</b>				10f. Zip Code <b>21208</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
Physician /Medical Examiner	11. Marital Status <b><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>			16b. Kind of Business/Industry <b>PROPRIETOR</b>				
	17. Father's Name (First, Middle, Last) <b>MAX</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>FURMAN RUTH MAROWITZ</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>NORMA FURMAN / WIFE</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 POMONA SOUTH APT. 3 - BALTIMORE, MD 21208</b>							
	20a. Method of Disposition <b><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HAR SINAI CONG.</b>			Date <b>09/26/2006</b>	20c. Location - City or Town, State <b>OWINGS MILLS, MD</b>			
	21. Signature of Funeral Service Licensee <b>Michael Kugler</b>	22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>dementia</b>								Approximate Interval Between Onset and Death <b>years</b>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Due to (or as a consequence of): <b>dementia</b>						
		b.	Due to (or as a consequence of):						
		c.	Due to (or as a consequence of):						
		d.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</b>	23c. If yes, outcome of pregnancy <b><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HTN, CAD</b>				23e. Did tobacco use contribute to the cause of death? <b><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</b>				
	25. Was case referred to medical examiner? <b><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b>	26. Place of Death (Check only one) Hospital: <b><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA</b> Other: <b><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b></b>			23f. Were autopsy findings available prior to completion of cause of death? <b><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</b>				
	27. Manner of Death <b><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</b>	28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>M</b>	28c. Injury at Work? <b><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b>	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b></b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>				
	29a. Certifier (Check only one) <b><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>								
	29b. Signature and title of certifier <b>Helen M. Gordon</b>	29c. License number <b>DOO51926</b>			29d. Date signed (Month, Day, Year) <b>September 24, 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen M. Gordon MD 6565 N. Charles St, Baltimore MD 21204</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>	32. Registrar's Signature <b>J. Smith</b>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30733  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death	
	Carroll T. Giese, Jr.				SEP 27, 2006	6:20 AM	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death	
	University of MD Medical Center			Baltimore		N/A	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN 30, 1938	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent							
10a. State MD	10b. County Baltimore	10c. City, Town or Location Catonsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 2116 Rockwell Avenue			10f. Zip Code 21228		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		Teacher / Coach		16b. Kind of Business/Industry Physical Education Public School Sys.	
17. Father's Name (First, Middle, Last) Carroll T. Giese, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Doris E. Giese				
19a. Informant's Name/Relationship (Type, Print) Patricia L. Giese, wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2116 Rockwell Avenue		Date 09/30/06			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee 		21228		22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
a. Intracranial Hemorrhage Due to (or as a consequence of): HASCVD							
b. Atrial Fibrillation Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
Approximate Interval Between Onset and Death 10 hours							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 							
29c. License number 16781							
29d. Date signed (Month, Day, Year) September 27, 2006							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amy Stump, M.D. 22 S. Greene Street Baltimore, MD 21201							
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

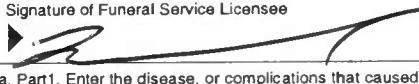
State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30734  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE H. GERHOLD, JR.</b>					2. Date of Death Month <b>09</b> Day <b>26</b> Year <b>2006</b>	3. Time of Death <b>9:55 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>8729 LACKAWANNA AVENUE</b>			4b. City, Town, or Location of Death <b>PARKVILLE</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>215-10-9073</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>11/8/1917</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent <b>8729 LACKAWANNA AVENUE</b>			10c. City, Town or Location <b>PARKVILLE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>MD BALTIMORE</b>			10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>12TH GRADE</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SUPERVISOR MACHINIST</b>			16b. Kind of Business/Industry <b>FEDERAL GOVERNMENT</b>	
	17. Father's Name (First, Middle, Last) <b>GEORGE H. GERHOLD, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ALIVE VIRGINIA SUDSBURG</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>PAMELA G. WATSON/DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>902 DELLWOOD DR. FALLSTON, MD 21047</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MOST HOLY REDEEMER CEMETERY</b>		Date <b>9/29/2006</b>	20c. Location - City or Town, State <b>BALTIMORE, MD</b>		
	21. Signature of Funeral Service Licensee 							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Malignant Neoplasm Brain</b> Approximate Interval Between Onset and Death <b>15 months</b>							
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>{</b> a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D0004126</b>					
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>9/26/06</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alberto J. Diaz, MD 7401 Osler Dr., Suite 103 - Towson MD 21284</b>							
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 2a or 28-a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, *WJ*  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30735  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Frazier Goodspeed</b>							2. Date of Death Month Day Year <b>September 10, 2006</b>	3. Time of Death 4:30 PM M
	4a. Facility Name (If not institution, give street and number) <b>28533 Augusta Court</b>			4b. City, Town, or Location of Death <b>Easton</b>			4c. County of Death <b>Talbot</b>		
Funeral Director	5. Social Security Number <b>465-14-6921</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months <b> </b>	If Under 24 Hrs. Days <b> </b>	8. Date of Birth (Month, Day, Year) <b>Dec 16, 1919</b>	9. Birthplace (State or Foreign Country) <b>TX</b>		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Talbot</b> 10c. City, Town or Location <b>Easton</b>			10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>					
To Be Completed by Funeral Director	10e. Street and Number <b>28533 Augusta Court</b>			10f. Zip Code <b>21601</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white</b>			14. Race - American Indian, Black, White, etc. <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Writer</b>			16b. Kind of Business/Industry <b>Publishing</b>		
	17. Father's Name (First, Middle, Last) <b>Herschel Goodspeed</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lavinia Frazier</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Anne Goodspeed/spouse</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28533 Augusta Ct. Easton, MD 21601</b>					
Physician /Medical Examiner	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>			22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. a. <b>Pulmonary Fibrosis</b> Due to (or as a consequence of): <b>Recurrent pneumonia</b> Due to (or as a consequence of): <b>Chronic Atrial Fibrillation</b> Due to (or as a consequence of):			Approximate Interval Between Onset and Death <b>10 yr., 3 yr., 3 yr.</b>		
	23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>					
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>			24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> 24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		
	27. Manner of Death <b>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred		
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29b. Signature and title of certifier <b>Robert M. McDonald, MD</b>			29c. License number <b>D009024</b>			29d. Date signed (Month, Day, Year) <b>9/18/06</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert M. McDonald, MD 30 Dover St. Easton, MD 21601</b>			32. Registrar's Signature <b>John S. Miller</b>					
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			33. Date signed (Month, Day, Year)					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30736

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gloria C. Gillis</b>							2. Date of Death Month 09 Day 20 Year 2006	3. Time of Death 12:16p <sup>M</sup>
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Nursing Home</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>213-34-8728</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>03 08 28</b>	9. Birthplace (State or Foreign Country) <b>Phillippines</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Perry Hall</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>415 Perry Hall Road</b>			10f. Zip Code <b>21128</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th grade</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) na Seamstress</b>			16b. Kind of Business/Industry <b>Professional</b>		
	17. Father's Name (First, Middle, Last) <b>Franciso Del-Coro</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ingracia Domingo</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Bonita Espinosa-Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4015 Perry Hall Road, Perry Hall, Md 21128</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Jala March</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet</b>		Date <b>9/27/06</b>	20c. Location - City or Town, State <b>Owings Mills, Md</b>			
	21. Signature of Funeral Service Licensee <i>Jala March</i>				22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore, Md 21215</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Medical Certification: To Be Completed by Physician/Medical Examiner	a. Due to (or as a consequence of): <b>metastatic uterine cancer</b> Approximate Interval Between Onset and Death <b>year</b>								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>M. Anthony Riley, MD</i>								
	29c. License number <b>D25205</b>								
	29d. Date signed (Month, Day, Year) <b>September 20, 2006</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C. A. Riley 6301 N. Charles St. Balt. md 21208</b>								
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <i>Isaac B. Spotts</i>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30737

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural" or Item 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death		
<i>Sherley B. Glass</i>	9	22	06	1250M			
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				4c. County of Death		
<i>HOWARD COUNTY GENERAL HOSP</i>	<i>COLUMBIA, MD</i>				<i>HOWARD</i>		
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
400-24-3750		82 Yrs.		December 29, 1923	Kentucky		
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Maryland	Howard	Columbia					
10e. Street and Number			10f. Zip Code	10g. Citizen of What Country? <i>U.S.A.</i>			
<i>5400 Vantage Point Rd. #302</i>			21044				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Industrial Engineer			16b. Kind of Business/Industry <i>Engineering</i>		
17. Father's Name (First, Middle, Last) <i>Irvin Louis Glass</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Wilhemina Schmidt</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Ms. Marie Glass Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6384 Dockser Terrace Falls Church, Virginia 22041</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Columbia Memorial Park</i>		Date 09/27/2006	20c. Location - City or Town, State <i>Clarksville, Maryland</i>			
21. Signature of Funeral Service Licensee <i>Johnathan Stahl, mss</i>		22. Name and Address of Facility <i>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death <i>minutes</i>	
<p>a. <i>acute MI</i> Due to (or as a consequence of):</p> <p>b. <i>CHD</i> Due to (or as a consequence of):</p> <p>c. <i>Diabetes mellitus</i> Due to (or as a consequence of):</p> <p>d. <i>claudication sexual failure</i></p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	<i>12/28/06</i>	<i>M</i>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Identifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Johnathan Stahl, mss</i>	29c. License number <i>D13998</i>			29d. Date signed (Month, Day, Year) <i>September 22, 2006</i>			
30. Name and address of person who completed cause of death (Item 2a) (Type, Print) <i>Johnathan Stahl, mss 4801 Dorsey Hall Dr. Ellicott City MD</i>							
31. Date filed (Month, Day, Year) <i>SEP 28 2006</i>	32. Registrar's Signature <i>Johnathan Stahl</i>						

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30738

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
MARY A. HARRISON		SEP 23 2006				6:55pm M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
University of Maryland Medical Center		BALTIMORE				N/A	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-12-3067			83			5-1-1923	N.Y.
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Md.	NA	Baltimore					
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?	
746 Bartlett Avenue		21218				USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+) 2 yrs.	Teachers Aid		Catholic Schools			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)					
Francis		Walls		Elizabeth		Fleet	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Patricia A. Barlow Daughter		3525 Joann Drive, Baltimore, Md. 21244					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
Baltimore Cem.				9-28-06	Baltimore, Md.		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility					
Joseph R. Walter Jr.		March F.H. East 1101 E. North Ave., Baltimore, Md. 21202					
23a. a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
a. Pulmonary Emboli Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. {							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Philip C. Dittmar MD				29c. License number P19694		29d. Date signed (Month, Day, Year) SEP 23 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip C. Dittmar MD 29 South Greene St. Baltimore, MD 21201							
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature Laura S. Foster					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30739

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gary Francis Harroll</b>							2. Date of Death Month Day Year <b>September 24, 2006</b>	3. Time of Death 1:39 p m	
	4a. Facility Name (If not institution, give street and number) <b>206 Chaucer Lane, Unit J</b>			4b. City, Town, or Location of Death <b>Bel Air</b>			4c. County of Death <b>Harford</b>			
Funeral Director	5. Social Security Number <b>217-64-4174</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>June 22, 1954</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Bel Air</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number <b>206 Chaucer Lane, Unit J</b>				10f. Zip Code <b>21014</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Auto mechanic</b>			16b. Kind of Business/Industry <b>auto service</b>			
17. Father's Name (First, Middle, Last) <b>Charles Harroll</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Audrey Brittingham</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Jane Harroll/wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>206 Chaucer Lane, Unit J, Bel Air, Md. 21014</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>			Date <b>09/27/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Brian A. Miller</b>				22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air Inc., 610 W. Macphail Rd., Bel Air, Md. 21014</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>Chanc</b>	
<p>a. <i>Esophageal cancer</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier <b>WA (Wade M.A.)</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>9707 Medical Center Dr Rockville, MD</b>									29c. License number <b>S 3177</b>	
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>John B. Gandy</b>								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

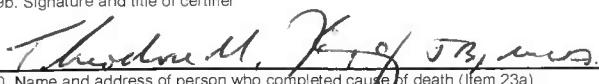
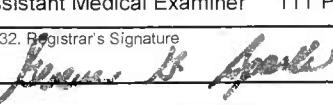
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Parrish Hargrove

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

2006 30740

1- For State  
Registrar

<b>Physician/ Medical Examiner</b>  <b>Funeral Director</b>	<b>1. Decedent's Name (First, Middle, Last)</b> <b>Parrish Hargrove</b> <b>4a Facility Name (if not institution, give street and number)</b> <b>1714 Druid Hill Avenue</b> <b>4b City, Town, or Location of Death</b> <b>Baltimore</b> <b>4c County of Death</b>										<b>Reg. No.</b> <b>2. Date of Death</b> <b>Month</b> <b>Day</b> <b>Year</b> <b>September</b> <b>10</b> , <b>2006</b>		<b>3 Time of Death</b> <b>1540 hrs</b>		
<b>To Be Completed by Funeral Director</b>  <small>Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</small>	<b>5. Social Security Number</b> <b>unk</b>		<b>6. Sex</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		<b>7. Age (In yrs. last birthday)</b> <b>34</b> <b>Yrs</b>		<b>If Under 1 Year</b> <b>Months</b> <b>Days</b>		<b>If Under 24 Hrs.</b> <b>Hours</b> <b>Min.</b>		<b>8. Date of Birth (MM/DD/YYYY)</b> <b>Sept 22, 1971</b>		<b>9. Birthplace (State or Foreign Country)</b> <b>unk</b>		
	<b>Usual Residence of Decedent</b> <b>10a. State</b> <b>10b. County</b> <b>10c. City, Town or Location</b> <b>MD</b> <b></b> <b>Baltimore</b>										<b>10d. Inside City Limits</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	<b>10e. Street and Number</b> <b>1328 McCullough Street</b>					<b>10f. Zip Code</b> <b>21217</b>					<b>10g. Citizen of What Country?</b> <b>USA</b>				
	<b>11. Marital Status</b> <b>unk</b> 1 <input type="checkbox"/> Never Married    2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed    4 <input type="checkbox"/> Divorced			<b>12. Was Decedent Ever in U.S. Armed Forces?</b> <b>unk</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>If Yes, Give Year or Dates:</small>			<b>13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>specify:</small>			<b>14. Race - American Indian, Black, White, etc.</b> <small>Specify:</small> <b>black</b>					
	<b>15. Decedent's Education (Specify only highest grade completed)</b> Elementary/Secondary (0-12)      College (1-4 or 5+)					<b>16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired)</b> <b>unk</b>					<b>16b. Kind of Business/Industry</b> <b>unk</b>				
	<b>17. Father's Name (First, Middle, Last)</b> <b>unk</b>					<b>unk</b>					<b>18. Mother's Name (First, Middle, Maiden Surname)</b> <b>unk</b>				
	<b>19a. Informant's Name/Relationship (Type, Print)</b> <b>O.C.M.E.</b>					<b>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)</b> <b>111 Penn Street Baltimore, MD 21201</b>									
	<b>20a. Method of Disposition</b> 1 <input type="checkbox"/> Burial    2 <input type="checkbox"/> Cremation    3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation    5 <input checked="" type="checkbox"/> Other Specify: <b>in state</b>					<b>20b. Place of Disposition (Name of cemetery, crematory or other place)</b>					<b>Date</b>		<b>20c. Location - City or Town, State</b>		
	<b>21. Signature of Funeral Service Licensee</b> <b>Ronald S. Ware, Director</b>					<b>22. Name and Address of Facility</b> <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>									
	<b>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</b>										<b>Approximate Interval Between Onset and Death</b>				
<b>Immediate Cause (Final disease or condition resulting in death)</b> <b>a. Cocaine and Narcotic intoxication</b> <small>Due to (or as a consequence of):</small>															
<b>b.</b> <small>Due to (or as a consequence of):</small>															
<b>c.</b> <small>Due to (or as a consequence of):</small>															
<b>d.</b>															
<input checked="" type="checkbox"/> UNPENDED			<input type="checkbox"/> AMENDED			<b>item#23a,27,28a-f,perME,g860, 10/2/06 TT</b>									
<b>IF FEMALE:</b> <b>23b. Was decedent pregnant in the past 12 months?</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    9 <input type="checkbox"/> Unknown					<b>23c. If yes, outcome of pregnancy</b> 1 <input type="checkbox"/> Live birth    2 <input type="checkbox"/> Fetal death    3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death    5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					<b>23d. Date of delivery</b> Month      Day      Year					
<b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b>										<b>23e. Did tobacco use contribute to the cause of death?</b> 1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Probably    4 <input checked="" type="checkbox"/> Unknown					
<b>25. Was case referred to medical examiner?</b> 1 <input checked="" type="checkbox"/> Yes    2 <input type="checkbox"/> No										<b>26 Place of Death (Check only one)</b> Hospital: 1 <input type="checkbox"/> Inpatient    2 <input type="checkbox"/> ER/Outpatient    3 <input type="checkbox"/> DDA    Other 4 <input type="checkbox"/> Nursing Home    5 <input type="checkbox"/> Residence    6 <input checked="" type="checkbox"/> Other: Scene					
<b>27. Manner of Death</b> 1 <input type="checkbox"/> Natural    5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident    6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide    4 <input type="checkbox"/> Homicide					<b>28a. Date of Injury (Month, Day, Year)</b> <b>Fnd 9/10/2006</b>		<b>28b. Time of Injury</b> <b>Fnd 3:18 pm</b>		<b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<b>28d. Describe how injury occurred</b> <b>unknown</b>				
<b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>Scene</b>										<b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b> <b>1714 Druid Hill Ave. Baltimore, MD</b>					
<b>29a. Certifier (Check only one)</b> 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated					<b>29b. Signature and title of certifier</b> 										
<b>30. Name and address of person who completed cause of death (Item 23a)</b> <b>Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>										<b>29c. License number</b> <b>O.C.M.E.</b>					
<b>31. Date filed (Month, Day, Year)</b> <b>SEP 28 2006</b>					<b>32. Registrar's Signature</b> 					<b>29d. Date signed (Month, Day, Year)</b> <b>September 11, 2006</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30741  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ellen Willie Mae Humphrey</b>						2. Date of Death Month 09 Day 23 Year 2006	3. Time of Death 5:00am M								
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris Towson</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>									
Funeral Director	5. Social Security Number <b>215-16-2849</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>01 18 21</b>	9. Birthplace (State or Foreign Country) <b>NC</b>									
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>NA</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No															
	10e. Street and Number <b>6506 Copper Ridge Dr Unit 101</b>			10f. Zip Code <b>21209</b>			10g. Citizen of What Country? <b>U.S.A.</b>									
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>XX</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>									
	15. Decedent's Education (Specify only highest grade completed) <b>12th grade</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing Assistant</b>			16b. Kind of Business/Industry <b>State of Maryland</b>									
	17. Father's Name (First, Middle, Last) <b>George Allen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen Brown</b>											
	19a. Informant's Name/Relationship (Type, Print) <b>Daughter Madeline Humphrey Gordan</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6506 Copper Ridge Dr. Unit 101, Baltimore, Md 21209</b>											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial</b>		Date <b>9/27/06</b>	20c. Location - City or Town, State <b>Arbutus, Md</b>										
	21. Signature of Funeral Service Licensee <b>Jala March</b>		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore, Md 21215</b>													
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
	<table border="1"> <tr> <td>a. Due to (or as a consequence of): <b>Cardiovascular Disease</b></td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Due to (or as a consequence of): <b>Hypertension</b></td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of): <b></b></td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of): <b></b></td> <td></td> </tr> </table>								a. Due to (or as a consequence of): <b>Cardiovascular Disease</b>	Approximate Interval Between Onset and Death	b. Due to (or as a consequence of): <b>Hypertension</b>		c. Due to (or as a consequence of): <b></b>		d. Due to (or as a consequence of): <b></b>	
a. Due to (or as a consequence of): <b>Cardiovascular Disease</b>	Approximate Interval Between Onset and Death															
b. Due to (or as a consequence of): <b>Hypertension</b>																
c. Due to (or as a consequence of): <b></b>																
d. Due to (or as a consequence of): <b></b>																
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown Other (specify): _____				23d. Date of delivery Month Day Year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Recurrent strokes</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred										
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
	29b. Signature and title of certifier <b>Eddie Nakhuda, M.D.</b>		29c. License number <b>D13504</b>			29d. Date signed (Month, Day, Year) <b>9 14 06</b>										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093</b>															
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>John B. Jones</b>													

5:05 A.M.

Baltimore, Maryland 21215-0036

WILLIAMEE HUMPHREY, SEPTEMBER 23, 2006, Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

original.

06-07203

Shana Henderson

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

2006 30742

## 1- For State Registrar

<b>Physician/ Medical Examiner</b>		1. Decedent's Name (First, Middle, Last) <b>Shana Henderson</b>					2. Date of Death Month Day Year <b>September 24, 2006</b>		3. Time of Death 1059 hrs		
		4a. Facility Name (if not institution, give street and number) <b>University Hospital</b>					4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death		
<b>Funeral Director</b>		5. Social Security Number <b>220-04-0070</b>	6. Sex <b>1 M 2 X F</b>	7. Age (In yrs. last birthday) <b>22 Yrs.</b>	If Under 1 Year Months <b> </b>	If Under 24hrs. Days <b> </b>	8. Date of Birth (MM/DD/YYYY) <b>10 14 83</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
		Usual Residence of Decedent 10a. State <b>MD</b>					10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	10d. Inside City Limits <b>1 X Yes 2 No</b>	
		10e. Street and Number <b>206 North Hilton Street</b>					10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
		11. Marital Status <b>1 X Never Married 2   Married</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1   Yes 2 X No</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1   Yes 2 X No specify:</b>					14. Race - American Indian, Black, White, etc. <b>Black</b>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Tour Guide</b>					16b. Kind of Business/Industry <b>USS Constellation</b>		
		17. Father's Name (First, Middle, Last) <b>James V. Henderson III</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Kimberly Noakes</b>				
		19a. Informant's Name/Relationship (Type, Print) <b>Kimberly Noakes-Mother</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>206 North Hilton Street, Baltimore Md 21229</b>				

To Be Completed by Funeral Director

20a. Method of Disposition <b>1 X Burial 2   Cremation 3   Removal from State</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>	Date <b>10/2/2006</b>	20c. Location - City or Town, State <b>Randallstown, Md</b>
4   Donation 5   Other Specify: <b> </b>	22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore, Md 21215</b>		

Signature of Funeral Service Licensee

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. Multiple Injuries Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1   Yes 2   No 9   Unknown</b>	23c. If yes, outcome of pregnancy 1   Live birth   2   Fetal death   3   Ectopic pregnancy 4   Pregnant at time of death   5   Other (Specify) <b>9   Unknown</b>	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <b>1   Yes 2   No 3   Probably 4   Unknown</b>
_____ _____		24a. Was an autopsy performed? <b>1   X Yes 2   No</b>
_____ _____		24b. Were autopsy findings available prior to completion of cause of death? <b>1   X Yes 2   No</b>

25. Was case referred to medical examiner? <b>1   X Yes 2   No</b>	26. Place of Death (Check only one) Hospital: <b>1   X Inpatient 2   ER/Outpatient 3   DOA 4   Nursing Home 5   Residence 6   Other:</b>				
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27. Manner of Death 1   Natural   5   Pending Investigation 2   X Accident   6   Could not be determined 3   Suicide   4   Homicide	28a. Date of Injury (Month, Day, Year) <b>FOUND: Sep 24, 2006</b>	28b. Time of Injury <b>FOUND: 0001 hrs</b>	28c. Injury at Work? <b>1   Yes 2   X No</b>	28d. Describe how injury occurred <b>Subject pedestrian struck by vehicle</b>
28e. Place of Injury - At home, farm, street, factory, office building, etc (Specify) <b>Local Street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>300 Hilton Parkway, Baltimore, MD</b>		

29a. Certifier (Check only one) <b>1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2   X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated</b>	29c. License number <b>O.C.M.E.</b>				
--	--	--	--	--	--

29b. Signature and title of certifier <b>Theodore M. King, Jr., MD.</b>	29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>				
--	--	--	--	--	--

30. Name and address of person who completed cause of death (Item 23a) <b>Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>
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31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>	32. Registrar's Signature <b>Rebecca S. Parker</b>
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Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

## Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2006 30743

1. For State  
RegistrarPhysician  
Medical ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year September 19, 2006	3. Time of Death 0746 hrs
Asa George Handelman			
4a. Facility Name (if not institution, give street and number) Northwest Hospital		4b. City, Town, or Location of Death Randallstown	
4c. County of Death Baltimore County			
5 Social Security Number 217-56-8410	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days Hours Min. 2/3/1952
8. Date of Birth (MM/DD/YYYY) 2/3/1952		9. Birthplace (State or Foreign Country) MD	
Usual Residence of Decedent 10a. State MD		10b. County Baltimore	
10c. City, Town or Location Randallstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 1 Spinners Court Apt. B		10f. Zip Code 21133	
10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman	16b. Kind of Business/Industry Sales
17. Father's Name (First, Middle, Last) Abraham handelman		18 Mother's Name (First, Middle, Maiden Surname) Margaret Louise Carter	
19a. Informant's Name/Relationship (Type, Print) Lindsey Handelman daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 E. North Ave. Baltimore, MD 21202	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Nedra Michele Bright MAR 23		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory	Date 9/25/06
21. Signature of Funeral Service Licensee		20c. Location - City or Town, State Baltimore, MD	
22. Name and Address of Facility Slack Funeral Home, P.A. MD 21043			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____			
<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED		item#23a,PTI,27,perME,g860, 10/17/06 TT	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Chronic obstructive pulmonary disease			
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc.	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number O.C.M.E.	
29b. Signature and title of certifier Theodore M. King, Jr., MD. Assistant Medical Examiner		29d. Date signed (Month, Day, Year) September 20, 2006	
30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature Reena R. Apothecary	

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

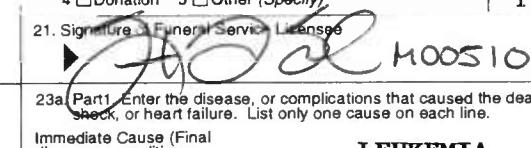
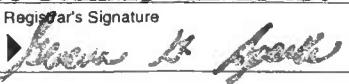
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30744

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stanley J. Knapik</b>							2. Date of Death Month Day Year <b>September 26, 2006</b>			3. Time of Death <b>1:45 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>			4b. City, Town, or Location of Death <b>Timonium</b>				4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>213-07-5870</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug. 21, 1915</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>2300 Dulaney Valley Rd., Apt W109</b>				10f. Zip Code <b>21093</b>			10g. Citizen of What Country? <b>U. S. A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates <b>1941-1945</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>			16b. Kind of Business/Industry <b>Steel Manufacturer</b>						
17. Father's Name (First, Middle, Last) <b>Stanley J. Knapik, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Karolina Kuc</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Helen T. Knapik (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2300 Dulaney Valley Rd, Apt W109, Timonium, Md. 21093</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>MOOSIO</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>			Date <b>09/29/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Galena Funeral Home 118 W. Cross St., Galena, Md. 21635</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LEUKEMIA</b>											Approximate Interval Between Onset and Death
a. Due to (or as a consequence of): <b>LEUKEMIA</b>											
b. Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
											24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
				M							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D43725</b>			29d. Date signed (Month, Day, Year) <b>9/26/06</b>				
29b. Signature and title of certifier 											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>											
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>				32. Registrar's Signature 							

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or if Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner shall be notified at [redacted].

SEPTEMBER 26, 2006 1:45 a.m.

Baltimore, Maryland 21215-0036

STANLEY KNAPIK

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial/transit

Division of Vital Records, P.O. Box 68760,   
Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2006 30745

### *Certificate of Death*

**Reg. No.**

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>JEAN A. KENNY</b>						2. Date of Death Month <b>09</b> Day <b>24</b> Year <b>2006</b>		3. Time of Death <b>5:00 PM</b>			
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>GILCHRIST NURSING CENTER</b>			4b. City, Town, or Location of Death <b>TOWSON</b>			4c. County of Death <b>BALTIMORE</b>					
To Be Completed by Funeral Director		5. Social Security Number <b>217-24-2673</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>10-12-1927</b>	9. Birthplace (State or Foreign Country) <b>MD</b>				
Usual Residence of Decedent		10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director		10e. Street and Number <b>5347 NELSON AVENUE</b>				10f. Zip Code <b>21215</b>			10g. Citizen of What Country? <b>USA</b>				
Physician /Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc.				
Baltimore, Maryland 21215-0036		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12TH GRADE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>N/A</b> <b>MATERIAL PROCESSOR</b>		16b. Kind of Business/Industry <b>ST. AGNES HOSPITAL</b>							
Important: If item 22 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at:		17. Father's Name (First, Middle, Last) <b>JAMES DOWNS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARTHA THOMAS</b>									
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.		19a. Informant's Name/Relationship (Type, Print) <b>EUGENE KENNY, JR (SON)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5347 NELSON AVE., 2ND FL., BALTO. MD 21215</b>									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Burial</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBLUTUS</b>		Date <b>09-29-06</b>			20c. Location - City or Town, State <b>BALTIMORE, MD</b>				
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.		21. Signature of Funeral Service Licensee <b>Danphe OJ</b>		22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL SERVICE</b> <b>5151 BALTO. NATL' PIKE, BALTO. MD 21229</b>									
Medical Certification: To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Gastric Cancer</b>						Approximate Interval Between Onset and Death <b>Weeks</b>					
IF FEMALE:		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one)  Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>HOSPICE</b>						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		29c. License number <b>DS8303</b>						29d. Date signed (Month, Day, Year) <b>September 25 2006</b>					
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Debra L. Apelt</b>									

Division of Vital Records, P.O. Box 68760,

**Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Baltimore, Maryland 21215-0036

**Baltimore, Maryland 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30746

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year			3. Time of Death	
Jaswinder Kaur			9	24	2006	7:45 AM	
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
Franklin Square Hospital			Rosedale			Baltimore	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-47-1813		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	42 Yrs.			MAR 1, 1964	India

Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
MD	Baltimore	Dundalk					
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
6704 Gary Ave			21222			USA	

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Asian
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
Tara Singh		Gurmeet Kaur	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Joginder S. Samra/husband		6704 Gary Ave Dundalk, MD 21222	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2006	20c. Location - City or Town, State Metro Crematory, Inc. 9/28 Baltimore, MD
21. Signature of Funeral Service Licensee Todd Dring MacNabb Funeral Home, P.A.		22. Name and Address of Facility 301 Frederick Rd Catonsville, MD 21228	Approximate Interval Between Onset and Death 2 years

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one disease on each line.		23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Immediate Cause (Final disease or condition resulting in death)		23c. Due to (or as a consequence of): Metastatic Breast cancer
{ Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Approximate Interval Between Onset and Death 2 years
a. Due to (or as a consequence of):		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
_____		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
_____		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	26. Place of Death (Check only one)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number	29d. Date signed (Month, Day, Year)
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29b. Signature and title of certifier Dr. S. Sankarava Siva Saitan MD	29c. License number D45530	29d. Date signed (Month, Day, Year) 09-24-2006
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. S. Sankarava Siva Saitan 9000 Franklin Square Drive Baltimore, MD 21215	31. Date filed (Month, Day, Year) SEP 28 2006	32. Registrar's Signature Karen B. Smith
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30747

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

		1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year		3. Time of Death 11:15 P M			
		Florence Kenton						August 31, 2006					
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death						4c. County of Death					
Greater Baltimore Medical Center		Towson						Baltimore					
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 4, 1918		9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent		10a. State MD		10b. County Baltimore		10c. City, Town or Location Lutherville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 11630 Glen Arm Road 154D						10f. Zip Code 21093		10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) unk		housewife		16b. Kind of Business/Industry own home							
17. Father's Name (First, Middle, Last) Charles Baker Lukens		18. Mother's Name (First, Middle, Maiden Surname) Edith Cooke											
19a. Informant's Name/Relationship (Type, Print) Lorraine Polvinale/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Garrison Forest Road Owings Mills, MD 21117		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ronald S. Wade, Director		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State Baltimore, MD 21201			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201											
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA MAL NUTRITION		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		23f. Approximate Interval Between Onset and Death 2 weeks			
Physician /Medical Examiner		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Ronald S. Wade, MD		29c. License number J51228		29d. Date signed (Month, Day, Year) 9/20/06					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMANATH GOPALAN MD, 212 ROLLING CROSSROADS #159 BETHESDA 20228		31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature Leanne B. Foster							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30748

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mary Kotula</i>				2. Date of Death Month 09 Day 26 Year 2006	3. Time of Death 1:00 a.m.		
	4a. Facility Name (If not institution, give street and number) <i>OAK CREST</i>		4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>Baltimore</i>			
Funeral Director	5. Social Security Number <i>220-22-2230</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>79</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day Year) <i>Feb 22, 1927</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>Baltimore</i>	10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>8810 Walther Blvd., Apt. 1208</i>		10f. Zip Code <i>21234</i>			10g. Citizen of What Country? <i>U.S.A.</i>		
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>				
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Own home</i>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Leon Paszek</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Theophilie Swinski</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Dr. Stanley Kotula-husband</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8810 Walther Blvd, Apt 1208, Baltimore, MD 21234</i>				
Medical Certification: To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>►</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holy Rosary</i>		Date <i>9/30/06</i>	20c. Location - City or Town, State <i>Dundalk, MD</i>		
	21. Signature of Funeral Service Licensee <i>William G. Dau</i>		22. Name and Address of Facility <i>Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204</i>					
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death) <i>Cerebrovascular disease</i></p> <p>Approximate Interval Between Onset and Death <i>10 years</i></p> <p>Due to (or as a consequence of): <i>►</i></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>{ a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):</p> <p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p>								
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><i>►</i> <i>Alzheimer's Disease</i></p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one)</p>								
<p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day Year) <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p>								
<p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>								
<p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier <i>► William Russell</i></p> <p>29c. License number <i>D30182</i></p> <p>29d. Date signed (Month, Day, Year) <i>September 26, 2006</i></p>								
<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>William RUSSELL, MD 8800 WALTER BLVD BALT, MD 21234</i></p>								
<p>31. Date filed (Month, Day, Year) <i>SEP 28 2006</i></p>								
<p>32. Registrar's Signature <i>James B. Apelt</i></p>								

9/24/06 at 1am

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30749

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ronald Allen Kanyuck</b>							2. Date of Death Month Day Year <b>September 24 2006</b>	3. Time of Death 1:45 AM		
	4a. Facility Name (If not institution, give street and number) <b>Baltimore Washington Medical Center</b>			4b. City, Town, or Location of Death <b>Glen Burnie</b>			4c. County of Death <b>Anne Arundel</b>				
Funeral Director	5. Social Security Number <b>219-40-3545</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 08 1943</b>	9. Birthplace (State or Foreign Country) <b>MD</b>				
	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Glen Burnie</b>								
	10e. Street and Number <b>504 Winton Avenue</b>			10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>USA</b>					
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1968-1970</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 2 Manager</b>		16b. Kind of Business/Industry <b>Electronics</b>						
17. Father's Name (First, Middle, Last) <b>Raymond A. Kanyuck</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Julian</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Sharon M. Kanyuck (spouse)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>504 Winton Avenue, Glen Burnie, MD 21061</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Hildy S. J.</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Cemetery</b>			Date <b>Sept. 27</b>	20c. Location - City or Town, State <b>Elkridge, Maryland</b>				
21. Signature of Funeral Service Licensee <b>Hildy S. J.</b>					22. Name and Address of Facility <b>Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Bladder Cancer</b>									Approximate Interval Between Onset and Death		
b. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Dehydration</b>											
c. Due to (or as a consequence of): <b>Hypercalcemia</b>											
d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
29b. Signature and title of certifier <b>George E. Wilks III M.D.</b>		29c. License number <b>D41365</b>					29d. Date signed (Month, Day, Year) <b>September 24, 2006</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>George E. Wilks III M.D. 301 Hospital Drive, Glen Burnie, MD 21061</b>											
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature <b>George E. Wilks</b>								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, MD

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30750

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

*Laswell, Maryland 21215-0036*

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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*Laswell, Maryland 21215-0036*

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
Alvin D. Laswell							September 21, 2006	11:51 AM
4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death	
Harford Memorial Hospital				Havre de Grace			Harford	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	II Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
214-36-8608			65 Yrs.			Sept 23, 1940	California	
Usual Residence of Decedent								
10a. State MD	10b. County Harford	10c. City, Town or Location Havre de Grace					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 818 S. Juniata Street #1				10f. Zip Code 21078			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0			16b. Kind of Business/Industry management			hotels
17. Father's Name (First, Middle, Last) Alex Laswell					18. Mother's Name (First, Middle, Maiden Surname) Lenore Jean Calder			
19a. Informant's Name/Relationship (Type, Print) Maria L. Laswell/spouse					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 S. Juniata Street #1 Havre de Grace, MD 21078			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>Ronald S. Wade Director</i>					22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								
a. Due to (or as a consequence of): <i>Arteriosclerotic cardiovascular disease</i>								
b. Due to (or as a consequence of): <i>coronary artery disease</i>								
c. Due to (or as a consequence of): <i>prostate Cancer</i>								
d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier <i>J.T. Lee MD</i>		29c. License number D20661			29d. Date signed (Month, Day, Year) 9/2/06			
30. Name and address of person who completed cause of death (Item 23a). (Type, Print) <i>J.T. Lee MD 669 Revolution St. Havre de Grace MD 21078</i>								
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature <i>Laura B. Smith</i>						

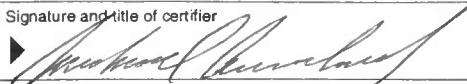
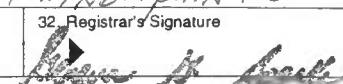
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30751  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard Carroll Lewis</b>					2. Date of Death Month <b>September</b> Day <b>26</b> Year <b>2006</b>	3. Time of Death 12:00 PM	
	4a. Facility Name (If not institution, give street and number) <b>5001 Tartan Hill Road</b>			4b. City, Town, or Location of Death <b>Perry Hall</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>212-48-9032</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>June 10, 1947</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Perry Hall</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>5001 Tartan Hill Road</b>			10f. Zip Code <b>21128</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Telephone Installer</b>		16b. Kind of Business/Industry <b>Telephone Company</b>				
	17. Father's Name (First, Middle, Last) <b>Carroll E. Lewis</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Nan Hiss</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Celeste Lewis (wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5001 Tartan Hill Rd., Perry Hall, MD 21128</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>9/30/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236</b>				
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>NON-SMALL Cell Lung Cancer</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	Approximate Interval Between Onset and Death <b>3 months</b>							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
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			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number <b>D33551</b>		29d. Date signed (Month, Day, Year) <b>9/28/06</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. AUERBACH 9110 Philadelphia Rd #314, Baltimore, MD 21237</b>							
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-tansit

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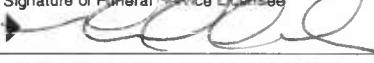
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30752  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kathryn Anne Longhi</b>						2. Date of Death Month Day Year <b>September 22, 2006</b>	3. Time of Death <b>11:12 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Rockville Nursing Home</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>177-16-6396</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>March 20, 1926</b>	9. Birthplace (State or Foreign Country) <b>New York</b>			
	Usual Residence of Decedent 10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Clarksburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>23912 Trading Post Drive</b>			10f. Zip Code <b>20871</b>			10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>3</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>3</b>	16b. Kind of Business/Industry <b>Homemaker</b>							
	17. Father's Name (First, Middle, Last) <b>Charles K. Tomlinson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Fraser</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Paul Melvin Longhi / Husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23912 Trading Post Drive, Clarksburg, Maryland 20871</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>M01433</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium Inc</b>		Date <b>September 25, 2006</b>	20c. Location - City or Town, State <b>Bethesda, Maryland</b>				
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Alzheimer's Dementia</b> Due to (or as a consequence of): b. _____ c. _____ d. _____								Approximate Interval Between Onset and Death Years	
	Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check on one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 		29c. License number <b>D41794</b>			29d. Date signed (Month, Day, Year) <b>September 22, 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Priscilla R. Callahan, M.D. 911 Russell Avenue, Gaithersburg, Maryland 20879</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature 							

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30753

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Katherine MacMillan</i>							2. Date of Death Month 09	Day 21	Year 06	3. Time of Death 1:30 AM
	4a. Facility Name (If not institution, give street and number) <i>Kenswick Multicare Center</i>			4b. City, Town, or Location of Death <i>Baltimore City</i>			4c. County of Death N/A				
Funeral Director	5. Social Security Number 220-01-0596	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 8, 1920	9. Birthplace (State or Foreign Country) MD				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD			10b. County N/A			10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 700 West 40th Street			10f. Zip Code 21211			10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Clothing				
	17. Father's Name (First, Middle, Last) William H. Marshall			18. Mother's Name (First, Middle, Maiden Surname) Ida Daily							
	19a. Informant's Name/Relationship (Type, Print) Michael Harold MacMillan (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 380 Euclid Avenue Daytona, FL 32118							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) LakeView Memorial			Date 9/29/6	20c. Location - City or Town, State Eldersburg, MD			
	21. Signature of Funeral Service Licensee <i>Marilyn Campbell</i>			22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Arteriosclerotic cardiovascular disease			Approximate Interval Between Onset and Death years				
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D25643			29d. Date signed (Month, Day, Year) 09/26/2006				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kendall R Faellner MD 6505 N. Charles St. Suite 201/Balto MD 21204</i>										
	31. Date filed (Month, Day, Year) SEP 28 2006			32. Registrar's Signature <i>Karen A. Faellner</i>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

## Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend item 26 per verb doc 8839 9-28-06 yr

State of Maryland / Department of Health and Mental Hygiene 2006 30754

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth V. Miller</b>							2. Date of Death Month Day Year <b>September 24, 2006</b>	3. Time of Death <b>6:05 PM</b>	
Funeral Director	4a. Facility Name (If not institution, give street and number) <b>401 Russell Avenue</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>			4c. County of Death <b>Montgomery</b>		
	5. Social Security Number <b>215-12-3657</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>January 23, 1920</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	10a. State <b>Maryland</b>				10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Gaithersburg</b>		
	10e. Street and Number <b>401 Russell Avenue</b>				10f. Zip Code <b>20877</b>			10g. Citizen of What Country? <b>United States of America</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Year</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>		16b. Kind of Business/Industry <b>Baltimore City Public School</b>					
	17. Father's Name (First, Middle, Last) <b>Samuel Leslie Conner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Noka May Wand</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Daughter</b> <b>Mona Elizabeth Taylor-Grim</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>248 Way Cross Way, Arnold, Maryland 21012</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Lorraine Park Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Cemetery</b>		Date <b>09/27/06</b>	20c. Location - City or Town, State <b>Woodlawn, Maryland 21207</b>				
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc</b> <b>8728 Liberty Road, Randallstown, Maryland 21133</b>				Approximate Interval Between Onset and Death <b>7 years</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Breast Cancer</b>									
	Immediate Cause (Final disease or condition resulting in death)									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	<p>a. Due to (or as a consequence of): <b>Breast Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 									
	29c. License number <b>0002234</b>									
	29d. Date signed (Month, Day, Year) <b>September 27, 2006</b>									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Manish Agrawal, MD 9707 Medical Center Drive, Suite 300, Rockville, MD 20850</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature 							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30755  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Robert Moore Sr.</b>					2. Date of Death Month Day Year <b>SEPT 20 2006</b>		3. Time of Death 6:50 PM
	4a. Facility Name (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>219-38-9221</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>07/18/1932</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>2135 Chelsea Terrace</b>			10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12<sup>th</sup> Grade</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Operator</b>			16b. Kind of Business/Industry <b>Dairy</b>	
	17. Father's Name (First, Middle, Last) <b>Louis Moore</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Davis</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Renee' K. Bureley (daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>651 Quincegate Rd, Baltimore MD 21224</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Vaughn C. Greene</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Cemetery</b>		Date <b>9/27/2006</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <b>Vaughn C. Greene</b>			22. Name and Address of Facility <b>Vaughn C. Greene Funeral Svcs 5151 Battle Knoll Pike, Baltimore, MD 21229</b>				
To Be Completed by Physician/Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. <b>NON SMALL CELL LUNG CANCER</b> Due to (or as a consequence of):</p> <p>u. <b>EMPHYSEMA</b> Due to (or as a consequence of):</p> <p>c. <b>CHRONIC OBSTRUCTIVE AIRWAY DISEASE</b> Due to (or as a consequence of):</p> <p>d.</p> <p>Approximate Interval Between Onset and Death <b>3 MONTHS</b></p> <p><b>YEARS</b></p>							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><b>HYPERTENSION</b></p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>P-18613</b>			29d. Date signed (Month, Day, Year) <b>September 20 2006</b>	
	29b. Signature and title of certifier <b>Muhammad Saad, M.D.</b>			29d. Date signed (Month, Day, Year) <b>September 20 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MUHAMMAD SAAD. 9005 CATON AVE. BALTIMORE, MD - 21229.</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>John B. Smith</b>					

MOORE, JAMES R  
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30756

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Drew Moccia</b>							2. Date of Death Month Day Year <b>September 23, 2006</b>	3. Time of Death a.m. or p.m. <b>7:30 a m</b>	
	4a. Facility Name (If not institution, give street and number) <b>2204 Candices Choice Court, Apt. A</b>			4b. City, Town, or Location of Death <b>Bel Air</b>			4c. County of Death <b>Harford</b>			
Funeral Director	5. Social Security Number <b>094-12-1971</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Feb. 27, 1922</b>	9. Birthplace (State or Foreign Country) <b>New York</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Bel Air</b> 10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number <b>2204 Candices Choice Court</b>			10f. Zip Code <b>21015</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 years</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>			16b. Kind of Business/Industry <b>own home</b>			
	17. Father's Name (First, Middle, Last) <b>Alfred Drew</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Raher</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara Lippiello/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1711 Boggs Road, Forest Hill, MD 21050</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Bayview Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>			Date <b>9/26/06</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>		
	21. Signature of Funeral Service Person 			22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc.</b> <b>610 W. MacPhail Road, Bel Air, Md. 21014</b>						
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Atherosclerotic cardiovascular disease</b>						Approximate Interval Between Onset and Death <b>one year</b>			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Due to (or as a consequence of): <b>a. Atherosclerotic cardiovascular disease</b>						
				b. Due to (or as a consequence of):						
				c. Due to (or as a consequence of):						
				d. _____						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>			29c. License number <b>435522</b>			29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>			
	29b. Signature and title of certifier 			29c. License number <b>435522</b>			29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARK WILD 2 NORTH AVENUE BEL AIR MARYLAND 21014</b>									
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

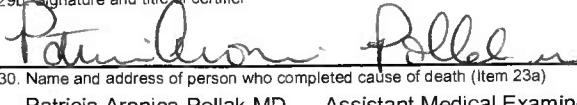
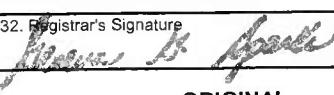
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

2006 30757

**1- For State Registrar**

Reg. No.

<b>Physician/ Medical Examiner</b>  <b>Funeral Director</b>	1. Decedent's Name (First, Middle, Last) <b>Roy Chester Milner</b>						2. Date of Death Month Day Year September 20, 2006		3. Time of Death 1535 hrs				
	4a. Facility Name (if not institution, give street and number) <b>5002 Conant Way</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>						
<b>To Be Completed by Funeral Director</b>	5. Social Security Number <b>218-44-2908</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		If Under 1 Year Months Days Hours Min. 0 0 0 0		8. Date of Birth (MM/DD/YYYY) <b>3/1/1946</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent <b>MD</b>		10a. State <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number <b>5002 Conant Way</b>				10f. Zip Code <b>21206</b>			10g. Citizen of What Country? <b>U.S.A.</b>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No <small>If Yes, Give Year or Dates:</small>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No <small>Specify:</small>			14. Race - American Indian, Black, White, etc. <small>Specify: Black</small>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>Correction Officer</b>								
	17. Father's Name (First, Middle, Last) <b>Chester Milner</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Shaw</b>										
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Milner (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>239 Bishop Ave, Baltimore, Md. 21225</b>										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other <small>Specify:</small>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		Date	20c. Location - City or Town, State <b>9/28/2006 Owings Mills, Md.</b>							
21. Signature of Funeral Service Licensed		22. Name and Address of Facility <b>Estep Brothers Funeral Home 1300 Eutaw Place, Baltimore, Md. 21217</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <small>Immediate Cause (Final disease or condition resulting in death)</small>													
a. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b> <small>Due to (or as a consequence of):</small>													
b. _____ <small>Due to (or as a consequence of):</small>													
c. _____ <small>Due to (or as a consequence of):</small>													
d. _____													
<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth      2 <input type="checkbox"/> Fetal death      3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death      5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
_____ _____										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA      Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural      5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident      6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide      7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. <small>(Specify)</small>		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <small>(Check only one)</small>													
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 21, 2006</b>									
30. Name and address of person who completed cause of death (Item 23a) <b>Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>													
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature 											

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30758

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural"; or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JL

State  
Registrar

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year				3. Time of Death		
John Thomas McMahon							September 25, 2006				3:10 PM		
4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death				4c. County of Death		
Rockville Nursing Home							Rockville				Montgomery		
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.			If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) October 14, 1928	9. Birthplace (State or Foreign Country) Rhode Island	
Usual Residence of Decedent													
10a. State	10b. County		10c. City, Town or Location							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Maryland	Montgomery		Potomac										
10e. Street and Number 9221 Falls Chapel Way							10f. Zip Code 20854				10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)							16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Claims Attorney				16b. Kind of Business/Industry Insurance		
17. Father's Name (First, Middle, Last) James Patrick McMahon							18. Mother's Name (First, Middle, Maiden Surname) Clara Frances McConnell						
19a. Informant's Name/Relationship (Type, Print) Eileen M. Evans / Daughter							19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15050 Camellia Lane, Montclair, Virginia 22025						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)							20b. Place of Disposition (Name of cemetery, crematory or other place) Gate Of Heaven Cemetery			Date September 29, 2006	20c. Location - City or Town, State Silver Spring, Maryland		
21. Signature of Funeral Service Licensee ► <i>Annette Evans</i>							22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ M01305 Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland, 20850-2805						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							23b. Due to (or as a consequence of): <i>Pneumonia</i> b. Due to (or as a consequence of): <i>Hypertensive Heart Disease</i> c. Due to (or as a consequence of): <i>Coronary Heart Disease</i> d. Due to (or as a consequence of): <i>Atrial Fibrillation</i>				Approximate Interval Between Onset and Death		
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier ► <i>Thomas V. Joseph</i>				29c. License number D0047330	29d. Date signed (Month, Day, Year) September 26, 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas V. Joseph, M.D. 50 West Edmonston Drive, #207, Rockville, Maryland 20852							31. Date filed (Month, Day, Year) SEP 28 2006				32. Registrar's Signature <i>John B. Smith</i>		
ORIGINAL													

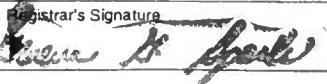
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30759

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles R. Maschke</b>							2. Date of Death Month Day Year <b>September 22, 2006</b>	3. Time of Death 6:40 PM		
	4a. Facility Name (If not institution, give street and number) <b>11231 Ashley Drive</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>				
Funeral Director	5. Social Security Number <b>205-26-0149</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 21, 1934</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>				
	Usual Residence of Decedent			10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>			10e. Street and Number <b>11231 Ashley Drive</b>		10f. Zip Code <b>20852</b>	10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>1956-</b> If Yes, Give Year or Dates: <b>1958</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Visual Information Specialist</b>			16b. Kind of Business/Industry <b>Federal Government</b>				
	17. Father's Name (First, Middle, Last) <b>George Maschke</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Merritt Maschke</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Marlys J. Maschke / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11231 Ashley Drive, Rockville, Maryland 20852</b>						
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>			Date <b>September 26, 2006</b>	20c. Location - City or Town, State <b>Silver Spring, Maryland</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home, Bethesda Chevy Chase, Inc.</b> <b>7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death <b>13 months</b>				
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year							
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>D59378</b>			29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Cheryl Aylesworth, MD. 2730 University Blvd. W., #400, Wheaton, Maryland 20902</b>			32. Registrar's Signature 							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2a or 2b-1 show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

19+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30760  
Certificate of Death

1- For  
State  
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>J REN MEZHEBOVSKAYA</b>							2. Date of Death Month <b>SEPT</b> Day <b>23</b> Year <b>2006</b>			3. Time of Death <b>0608 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GEN. HOSPITAL</b>			4b. City, Town, or Location of Death <b>COLUMBIA</b>				4c. County of Death <b>HOWARD</b>				
Funeral Director	5. Social Security Number <b>213-43-7973</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>MARCH 18, 1925</b>	9. Birthplace (State or Foreign Country) <b>Russia</b>					
Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Howard</b> 10c. City, Town or Location <b>Columbia</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
10e. Street and Number <b>7080 Cradlerock Way Apt 418</b>				10f. Zip Code <b>21045</b>			10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>4</b> <b>English Teacher</b>			16b. Kind of Business/Industry <b>Education</b>					
17. Father's Name (First, Middle, Last) <b>Rafail Mezhebovskaya</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Eugenia Parizher</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Alla Horti Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8452 Roberts Rd. Ellicott City, Maryland 21043</b>								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Melody Mezhebovskaya</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>			Date <b>09/28/2006</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>				
21. Signature of Funeral Service Licensee <b>Melody Mezhebovskaya</b>				22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>END STAGE RENAL DISEASE</b> Due to (or as a consequence of):</p> <p>b. <b>DIABETES MELLITUS</b> Due to (or as a consequence of):</p> <p>c. <b>HYPERTENSION</b> Due to (or as a consequence of):</p> <p>d. <b>MYELODYSPLASTIC SYNDROME</b></p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
<p><b>ANEMIA</b></p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p>												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <b>Attorney</b>				29c. License number <b>DDPS 59648</b>			29d. Date signed (Month, Day, Year) <b>SEP 23 2006</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JONES TANNESA NO 300 ARNON PLACE BALTIMORE MD 21217</b>												
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>				32. Registrar's Signature <b>Jones</b>								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30761

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Persing G. Ordansa

2. Date of Death

Month

Day

Year

3. Time of Death

7:05PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Baltimore Washington Hospital Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

5. Social Security Number

218-60-2713

6. Sex

M  F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year  
Months

If Under 24 Hrs.  
Days

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

06/12/1922

9. Birthplace (State or Foreign  
Country)

Hawaii

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

Yes  No

10e. Street and Number

388 West Court Unit 2C

10f. Zip Code

21061

10g. Citizen of What Country?

United States

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

Yes  No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify:

Philipino

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) 3

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Seaman

16b. Kind of Business/Industry

Merchant Marine

17. Father's Name (First, Middle, Last)

Rufino Ordansa

18. Mother's Name (First, Middle, Maiden Surname)

Antonia Guerrero

19a. Informant's Name/Relationship (Type, Print)

Caridad Ordansa - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

388 West Court Unit 2C Glen Burnie, Maryland 21061

20a. Method of Disposition

Burial 1  Cremation 2  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Holy Rosary Cemetery 09/29/2006 Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kathleen A. Weber CFSP David J. Weber Funeral Homes P.A.  
401 S. Chester Street Baltimore, Maryland 21231

22. Name and Address of Facility

401 S. Chester Street Baltimore, Maryland 21231

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

Approximate  
Interval Between  
Onset and Death

Metabolic Acidosis

Due to (or as a consequence of):

b. Renal Failure

Due to (or as a consequence of):

c. Septic Shock

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1  Yes 2  No  
9  Unknown

23c. If yes, outcome of pregnancy  
1  Live birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery  
Month Day Year

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prestate Cancer

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical  
examiner?  
1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA

Other:

4  Nursing Home 5  Residence 6  Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1  Natural 5  Pending investigation  
2  Accident 6  Could not be determined  
3  Suicide 4  Homicide

28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M 1  Yes 2  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Maria GAVIRIA MD

29c. License number

D0032744

29d. Date signed (Month, Day, Year)

September 26, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIA GAVIRIA MD 801 Hospital Dr Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

SEP 28 2006

32. Registrar's Signature

Anna B. Gaviria

ORIGINAL

**Please Type or Print in Black Indelible Ink**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2006 30762

1. For State  
Realstar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0740 hrs
<b>Michelle Lee Osbourne</b>	September 18, 2006	

**Funeral  
Director**

4a. Facility Name (if not institution, give street and number) <b>1625 Shookstown Road</b>	4b. City, Town, or Location of Death <b>Frederick</b>	4c. County of Death <b>Frederick</b>	
5. Social Security Number <b>unk</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>35 Yrs.</b>	If Under 1 Year Months Days Hours Min.

7A46  
Baltimore, MD 21215-0036  
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

10a. State <b>MD</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Frederick</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>1625 Shookstown Road</b>		10f. Zip Code <b>21702</b>	10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Elementary/Secondary (0-12) 12</b> <b>College (1-4 or 5+) 0</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b> <b>College (1-4 or 5+) 0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>	16b. Kind of Business/Industry <b>unk</b>
17. Father's Name (First, Middle, Last) <b>Raymond Frye</b>		18 Mother's Name (First, Middle, Maiden Surname) <b>Barbara Miss</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Trevor Frye/brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>103 Virgo Lane Martinsburg, WV 25404</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other Specify: <b>in state</b>	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
21. Signature of Funeral Service Licensee <b>Ronald S. Wade Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>	

**Physician/  
Medical  
Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) <b>a Cardiac arrhythmia</b> Due to (or as a consequence of): <b>b Myocardial fibrosis</b> Due to (or as a consequence of): <b>c</b> Due to (or as a consequence of): <b>d</b>			
<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED item#23a-b, PII,27, perME,g860, 10/20/06 TT			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Malignant neoplasm of lung; schizophrenia</b>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene	
27. Manner of Death <b>1 Natural</b> <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29d. Date signed (Month, Day, Year) <b>September 19, 2006</b>	
29b. Signature and title of certifier <b>Zabiullah Ali, M.D.</b>		29c. License number <b>O.C.M.E.</b>	
30. Name and address of person who completed cause of death (Item 23a) <b>Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>		31. Date filed (Month, Day, Year) <b>SEP 28 2006</b> 32. Registrar's Signature <b>Steve B. Spotts</b>	

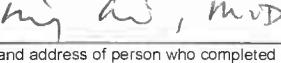
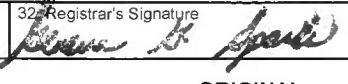
**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No.

2006 30763

**1. For State Registrar**

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carol M. Pridgeon</b>						2. Date of Death Month Day Year <b>September 23, 2006</b>		3. Time of Death 1838 hrs			
Funeral Director	4a. Facility Name (if not institution, give street and number) <b>326 Ellsworth Place</b>			4b. City, Town, or Location of Death <b>Joppa</b>			4c. County of Death <b>Harford</b>					
To Be Completed by Funeral Director	5. Social Security Number <b>217-62-5235</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b>		8. If Under 1 Year Months Days Hours Min. Yrs.			9. Date of Birth (MM/DD/YYYY) <b>March 1, 1955</b>			
To Be Completed by Funeral Director	10a. State <b>Md.</b>			10b. County <b>Harford</b>			10c. City, Town or Location <b>Joppa</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>326 Ellsworth Place</b>			10f. Zip Code <b>21085</b>			10g. Citizen of What Country? <b>U.S.A.</b>					
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>nurse</b>			16b. Kind of Business/Industry <b>health care</b>					
To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) <b>Frank J. Mannino</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace P. Gailey</b>							
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) <b>Martin Pridgeon/husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>326 Ellsworth Place, Joppa, Md. 21085</b>			Date <b>9/27/06</b>			20c. Location - City or Town, State <b>Baltimore, Md.</b>		
Physician / Medical Examiner	21. Signature of Funeral Service Licensee 									22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014</b>		
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Hypertensive atherosclerotic cardiovascular disease</b> Due to (or as a consequence of): b. _____ c. _____ d. _____									Approximate Interval Between Onset and Death		
Physician / Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown									23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene									
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
Medical Certification: To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated									29b. Signature and title of certifier 		
Medical Certification: To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) <b>Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>									29c. License number <b>O.C.M.E.</b>		
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature 						29d. Date signed (Month, Day, Year) <b>September 24, 2006</b>		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30764

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lewis Edward Patrick</b>							2. Date of Death Month <b>09</b> Day <b>23</b> Year <b>06</b>	3. Time of Death <b>10:40 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>			4b. City, Town, or Location of Death <b>Rosedale</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>404-54-0162</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Feb. 20, 1943</b>	9. Birthplace (State or Foreign Country) <b>Kentucky</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Nottingham</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>4400 Darleigh Road</b>			10f. Zip Code <b>21236</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Master Electrician</b>			16b. Kind of Business/Industry <b>Electric Co.</b>		
	17. Father's Name (First, Middle, Last) <b>Lewis Patrick</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Goldie Thacker</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Vera M. Patrick (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4400 Darleigh Road, Nottingham, MD 21236</b>				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Moreland Mem'l Park</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Mem'l Park</b>			Date <b>9/27/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Brian A. Meier</b>				22. Name and Address of Facility <b>Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>MI</b>							Approximate Interval Between Onset and Death	
	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Atherosclerosis Vascular Disease</b>								
	c. <b>Hypertension</b> Due to (or as a consequence of): <b>Obesity</b>								
	d.								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <b>Michael Pipkin</b>		29c. License number <b>D 54428</b>			29d. Date signed (Month, Day, Year) <b>09/23/2006</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Michael Pipkin 9000 Franklin Square Drive Baltimore, Md 21237</b>								
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Laura B. Apelt</b>						

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State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30765  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Julia D. Pentz</b>							2. Date of Death Month Day Year <b>September 23, 2006</b>			3. Time of Death <b>5:50 A M</b>			
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Center</b>			4b. City, Town, or Location of Death <b>Towson</b>				4c. County of Death <b>Baltimore</b>						
Funeral Director	5. Social Security Number <b>213-14-5708</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88 Yrs.</b>		If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>March 19, 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
	Usual Residence of Decedent													
	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number <b>9642 Dundawan Road</b>				10f. Zip Code <b>21236</b>			10g. Citizen of What Country? <b>U.S.A.</b>						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>						16b. Kind of Business/Industry <b>Typing and Mimeographing Company</b>				
	17. Father's Name (First, Middle, Last) <b>Carmello DiMaggio</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Clementina Farrari</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Julia R. Jett (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4423 Forge Road, Perry Hall, MD 21128</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Burial</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Joseph Ch. Cemetery</b>			Date <b>9/26/06</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>						
	21. Signature of Funeral Service Licensee <b>Brian A. Miller</b>				22. Name and Address of Facility <b>Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236</b>									
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>CVA</b>										Approximate Interval Between Onset and Death <b>days</b>			
	<b>a.</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of): 													
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>Unknown</b>						23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D0051926</b>								29d. Date signed (Month, Day, Year) <b>September 23, 2006</b>			
	29b. Signature and title of certifier <b>Helen M. Gordon MD</b>													
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen M. Gordon MD 6585 N. Charles St Baltimore MD 21204</b>													
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Karen K. Spalter</b>											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

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Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28b show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

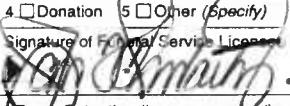
Certificate of Death

2006 30766

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Francis Leslie Pollard, Sr.		September 22, 2006				2044 M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Upper Chesapeake Medical Center		Bel Air				Harford	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 2, 1924	9. Birthplace (State or Foreign Country) England
078-22-5826							
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State Md.	10b. County Harford	10c. City, Town or Location Joppa					
10e. Street and Number 519 Stans Road		10f. Zip Code 21085				10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) supervisor		16b. Kind of Business/Industry Arundel Corporation			
17. Father's Name (First, Middle, Last) John Harold Pollard		18. Mother's Name (First, Middle, Maiden Surname) May Gamber					
19a. Informant's Name/Relationship (Type, Print) Gloria M. Pollard/wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 Stans Road, Joppa, MD 21085					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns		Date	20c. Location - City or Town, State Timonium, Md.		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		<i>Myocardial infarction</i> <i>atherosclerotic vascular disease</i>				Approximate Interval Between Onset and Death	
23b. Part II. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):  <i>Myocardial infarction</i> <i>atherosclerotic vascular disease</i>	b. Due to (or as a consequence of):  <i>Myocardial infarction</i> <i>atherosclerotic vascular disease</i>	c. Due to (or as a consequence of):  <i>Myocardial infarction</i> <i>atherosclerotic vascular disease</i>	d. Due to (or as a consequence of):  <i>Myocardial infarction</i> <i>atherosclerotic vascular disease</i>		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 00036487				29d. Date signed (Month, Day, Year) 9/24/06	
29b. Signature and title of certifier 							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Bentham Upper Chesapeake Medical Centre							
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature 					

2044

9-22-06

Pollard, Francis  
Division of Vital Records, P.O. Box 68760, J

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2006 30767

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gina Patterson</b>				2. Date of Death Month 09 Day 23 Year 2006	3. Time of Death 12:58a M	
	4a. Facility Name (If not institution, give street and number) <b>2525 Pottspring Road #S521</b>		4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>217-54-4165</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>11 03 57</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>2525 Pottspring Road #S521</b>			10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Elementary/Secondary (0-12) 12th grade</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>College (1-4 or 5+) 4yrs</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Director of Admissions</b>		16b. Kind of Business/Industry <b>University of MD School of Medicine</b>		
	17. Father's Name (First, Middle, Last) <b>Theodore C. Patterson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sylvia Tureaud</b>		19a. Informant's Name/Relationship (Type, Print) <b>Father Theodore C. Patterson</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2525 Pottspring Road #S521, Timonium, Md 21093</b>
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD National</b>		Date <b>9/30/06</b>	20c. Location - City or Town, State <b>Laurel, Md</b>	
	21. Signature of Funeral Service Licensee <b>March F/H West</b>		22. Name and Address of Facility <b>4300 Wabash Ave, Baltimore, Md 21215</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Liver failure</b> Approximate Interval Between Onset and Death <b>1M</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>Rectal small cell cancer metastases</b> <b>2Y</b>							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3. Ectopic pregnancy <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Hypertension</b>							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Did alcohol use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
5. Pending investigation 6. Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  <b>PETER HAUSNER, MD, PhD</b>							
29b. Signature and title of certifier <b>PETER HAUSNER, MD, PhD</b>		29c. License number <b>048160</b>		29d. Date signed (Month, Day, Year) <b>9/25/06</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PETER HAUSNER, MD, PhD, 22 South Greene Street, Baltimore MD 21201</b>							
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>							
32. Registrar's Signature <b>John B. Spack</b>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30768  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carolyn Graham Poole</b>					2. Date of Death Month Day Year <b>September 23, 2006</b>	3. Time of Death 5:10 P M
	4a. Facility Name (If not institution, give street and number) <b>10031 Clue Drive</b>			4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>214-28-4494</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>February 26, 1932</b>	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Bethesda</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>10031 Clue Drive</b>				10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Elementary/Secondary (0-12) 12</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>College (1-4 or 5+) Health Aide</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Health Aide</b>			16b. Kind of Business/Industry <b>Montgomery County Public Schools</b>	
17. Father's Name (First, Middle, Last) <b>Emory Carlton Crouch</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Winifred Powell</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Richard Wright / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5902 Jarvis Lane, Bethesda, Maryland 20814</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Gate Of Heaven Cemetery</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>September 27, 2006</b>	20c. Location - City or Town, State <b>Silver Spring, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Annette Ranauf</b>			22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a. <b>Sepsis</b> Due to (or as a consequence of):  b. <b>Abdominal Abscesses</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Ava Kaufman</b>		29c. License number <b>D26259</b>		29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ava Kaufman, MD 8218 Wisconsin Avenue, #103, Bethesda, Maryland 20814</b>							
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>B. Poole</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2006 30769

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

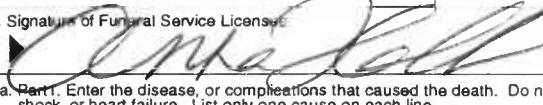
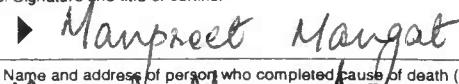
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Pryor, Helen

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		Helen Rita Pryor				2. Date of Death Month Month Day Year	3. Time of Death 6:05 PM
4a. Facility Name (If not institution, give street and number)		ST. AGNES HOSPITAL				4c. County of Death	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 8, 1922	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent							
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Catonsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 719 Maiden Choice Lane HR 314		10f. Zip Code 21228				10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		Personnel Administrator		16b. Kind of Business/Industry Banking	
17. Father's Name (First, Middle, Last) Joseph P. Schneider				18. Mother's Name (First, Middle, Maiden Surname) Helen Matilda Faulhaber			
19a. Informant's Name/Relationship (Type, Print) Helen Gross		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 9305 Meadow Hill Road, Ellicott City, MD 21042					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 9/25/2006		20c. Location - City or Town, State Catonsville, MD	
21. Signature of Funeral Service Licensee 							
22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. HYPOXIA Due to (or as a consequence of):  b. ATRIA FIBRILLATION (PACEMAKER IN SITU) Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Approximate Interval Between Onset and Death 3 hrs 10 hrs							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>S/P Surgery, Sick Sinus Syndrome, TIA, COPD, Chr. Kidney disease</i>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number P19926					
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 9/23/06					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mangat, Mangat 900 Caton Ave, BALTIMORE, MD 21229</i>							
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature 					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30770

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Laura A. Pfeiffer</b>							2. Date of Death Month Day Year <b>September 21, 2006</b>	3. Time of Death 9:44 a.m.M	
	4a. Facility Name (If not institution, give street and number) <b>Brighton Gardens Assisted Living</b>				4b. City, Town, or Location of Death <b>Columbia</b>			4c. County of Death <b>Howard</b>		
Funeral Director	5. Social Security Number <b>217-01-5628</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>July 27, 1917</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>Maryland</b>		10b. County <b>Howard</b>	10c. City, Town or Location <b>Columbia</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>7110 Minstral way</b>					10f. Zip Code <b>21045</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify:		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>1</b>			16b. Kind of Business/Industry <b>Clerk</b>			Post Office	
17. Father's Name (First, Middle, Last) <b>Jacob I. Makinson</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Annie L. Grimes</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Ms. Laura K. Kirkwood Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8784 Cloudleap Ct. #13 Columbia, Maryland 21045</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Melody Baker Bright</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Chapel Cemetery</b>			Date <b>9-25-06</b>	20c. Location - City or Town, State <b>Pfeifers Corner, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Melody Baker Bright</b>			22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Alzheimer's dementia</b>										Approximate Interval Between Onset and Death <b>5 years</b>
<p>{</p> <p>a. Due to (or as a consequence of): <b>Alzheimer's dementia</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year <b>N/A</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Debtility</b>										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown <b>No</b>
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ASSISTED LIVING</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Harry Li, M.D.</b>			29c. License number <b>D 56531</b>			29d. Date signed (Month, Day, Year) <b>Sept 22, 2006</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Harry Li, 8600 Snowden River pkwy, Ste 301, Columbia, MD 21045</b>										
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature <b>John B. Gandy</b>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30771

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLEO QUINERLY</b>							2. Date of Death Month Day Year <b>SEPTEMBER 24 2006</b>	3. Time of Death 12:51 PM	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL</b>			4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>			4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>239-48-6175</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>July 10, 1936</b>	9. Birthplace (State or Foreign) <b>North Carolina</b>			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>					10d. Inside City Limits <input checked="" type="checkbox"/>		
	10e. Street and Number <b>1716 Braddish Avenue</b>				10f. Zip Code <b>21216</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status  1 <input type="checkbox"/> Never Married   2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed   4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 <input type="checkbox"/> Yes   2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 <input type="checkbox"/> Yes   2 <input checked="" type="checkbox"/> No   Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)   12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  College (1-4 or 5+)   Truck Driver			16b. Kind of Business/Industry <b>Keystone Electric Co.</b>			
	17. Father's Name (First, Middle, Last) <b>Jasper Quinerly</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Victoria Quinerly</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Ernestine Quinerly Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1726 Braddish Avenue Baltimore, Maryland 21216</b>						
	20a. Method of Disposition  1 <input type="checkbox"/> Burial   2 <input type="checkbox"/> Cremation   3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation   5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery &amp; Chapel</b>			Date <b>09/30/06</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>		
	21. Signature of Funeral Service Licensee  <i>Paul A. Estep, Sr.</i>			22. Name and Address of Facility <b>Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>PULMONARY EMBOLUS</b>								Approximate Interval Between Onset and Death	
Physician /Medical Examiner	23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <i>{</i> a. Due to (or as a consequence of): <b>PULMONARY EMBOLUS</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes   2 <input type="checkbox"/> No   9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth   2 <input type="checkbox"/> Fetal death   3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death   5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>COLON CANCER</b>								23e. Did tobacco use contribute to the cause of death?  1 <input type="checkbox"/> Yes   2 <input type="checkbox"/> No   3 <input type="checkbox"/> Probably   4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes   2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes   2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes   2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient   2 <input type="checkbox"/> ER/Outpatient   3 <input type="checkbox"/> DOA   Other: 4 <input type="checkbox"/> Nursing Home   5 <input type="checkbox"/> Residence   6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input type="checkbox"/> Natural   5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident   6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide   4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M   1 <input type="checkbox"/> Yes   2 <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>D 54352</b>						29d. Date signed (Month, Day, Year) <b>SEPTEMBER 24 2006</b>
	29b. Signature and title of certifier  <i>Todd, MD</i>			29c. License number <b>D 54352</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NORTHWEST HOSPITAL</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MIRCEA TODOR</b>						
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature  <i>Mircea Todor</i>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene  
*Certificate of Death* 2006 30772  
Reg. No.

Physician /Medical Examiner		John Reisinger		Date of Death Month Day Year September 25 2006	Time of Death 00:32 M
Funeral Director		The Johns Hopkins Hospital Baltimore City		4c. County of Death Maryland	
To Be Completed by Funeral Director		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death Baltimore City	
		5. Social Security Number 216-07-1632		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
		7. Age (In yrs last birthday) 89 Yrs.		If Under 1 Year Months Days Hours Min.	
		8. Date of Birth (Month, Day, Year) 07/31/1917		9. Birthplace (State or Foreign Country) Maryland	
		10a. State Maryland		10b. County N/A	
		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number 2542 Fait Avenue		10f. Zip Code 21224	
		10g. Citizen of What Country? United States			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Improvements	
		16b. Kind of Business/Industry Contracting			
		17. Father's Name (First, Middle, Last) John E. Reisinger		18. Mother's Name (First, Middle, Maiden Surname) Annie Evans	
		19a. Informant's Name/Relationship (Type, Print) Rose Reisinger - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2542 Fait Avenue Baltimore, Maryland 21224	
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bayview Crematory		Date	20c. Location - City or Town, State Baltimore, Maryland
		21. Signature of Funeral Service Licensee David J. Weber		22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231	
		23a. Part 1. Enter the disease, if any, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 36 hours	
		a. <u>Intracerebral hemorrhage</u> Due to (or as a consequence of):			
		b. _____ Due to (or as a consequence of):			
		c. _____ Due to (or as a consequence of):			
		d. _____			
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____	
		23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atrial fibrillation, anticoagulation,</u> <u>Hypertension</u>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred	
		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Matthew Koenig MD	
		29c. License number D0063482		29d. Date signed (Month, Day, Year) September 25, 2006	
		30. Name and address of person who completed cause of death (item 23a) (Type, Print) Matthew Koenig 600 N. Wolfe Street Baltimore, MD 21287			
		31. Date filed (Month, Day, Year) SEP 28 2006	32. Registrar's Signature <i>M. Koenig</i>		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.					
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit					
Physician /Medical Examiner		Medical Certification; To Be Completed by Physician/Medical Examiner			
Division of Vital Records, P.O. Box 68760,					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.					
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit					
Physician /Medical Examiner		Medical Certification; To Be Completed by Physician/Medical Examiner			
Baltimore, Maryland 21215-0036					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.					

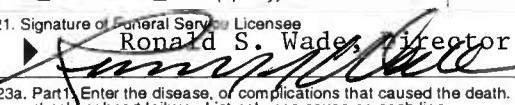
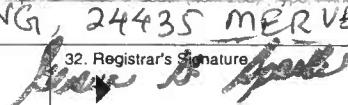
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30773

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard Carroll Reeder</b>							2. Date of Death Month Day Year <b>September 14, 2006</b>	3. Time of Death <b>7:14 AM<sup>M</sup></b>			
	4a. Facility Name (If not institution, give street and number) <b>23928 Marvell Dean Road</b>			4b. City, Town, or Location of Death <b>Hollywood</b>			4c. County of Death <b>St. Mary's</b>					
Funeral Director	5. Social Security Number <b>214-36-9111</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug 29, 1938</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>St. Marys</b> 10c. City, Town or Location <b>Hollywood</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>23928 Mervell Dean Road</b>			10f. Zip Code <b>20636</b>			10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>'61-63</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>none</b>			16b. Kind of Business/Industry <b>Carpenter</b>			16c. Kind of Business/Industry <b>Construction</b>				
	17. Father's Name (First, Middle, Last) <b>Raymond Cement Reeder</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Leona Anderson Crother</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Maryland State Police</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unknown</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>chronic Obstructive Pulmonary disease</b>									Approximate Interval Between Onset and Death		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>cirrhosis liver with ascites, lymphadenopathy, stasis ulcers glans, arthritis, on prednisone, chronic alcohol abuse, nicotine (cigarettes)</b>									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day/Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>KAE T. HUNG, 24435 MERVELL DEAN RD. HOLLYWOOD, MD 20636</b>									28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number <b>D 0051738</b>					29d. Date signed (Month, Day, Year) <b>09.18.2006</b>	
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>					32. Registrar's Signature 						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at all times.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30774

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Thomas M. Roberson	August 28, 2006	6:55 PM M

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
1200 Larchmont Avenue	Capital Heights	Prince George's			
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec 4, 1959	9. Birthplace (State or Foreign Country) DC

10a. State MD	10b. County Prince Georges	10c. City, Town or Location Capital Heights	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1200 Larchmont Avenue		10f. Zip Code 20743	10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) none	16b. Kind of Business/Industry substitute teacher
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17. Father's Name (First, Middle, Last) Thomas Aloysius Washington	18. Mother's Name (First, Middle, Maiden Surname) Doris Gloria Jones
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19a. Informant's Name/Relationship (Type, Print) Daphne Gray/sister	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Larchmont Ave. Capital Heights, MD 20743
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
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21. Signature of Funeral Service Licensee Ronald S. Wade, Director	22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
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23a. Part I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. Due to (or as a consequence of):  Diabetes with Complications	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A. Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier Salvador Sylvester	29c. License number 10055927	29d. Date signed (Month, Day, Year) September 15, 2006
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester 3rd Hospital Drive Chevy Chase Maryland
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31. Date filed (Month, Day, Year) SEP 28 2006	32. Registrar's Signature Ronald S. Wade
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State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30775

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>John Reed</i>		<i>September 25 2006</i>		<i>5357 M</i>
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Northwest Hospital</i>		<i>Randallstown</i>		<i>Baltimore</i>
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78</i>	If Under 1 Year Months Days Hours Min	8. Date of Birth (Month, Day, Year) <i>July 03, 1928</i>
9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>				
Usual Residence of Decedent				
10a. State <i>Maryland</i>	10b. County <i>Baltimore</i>	10c. City, Town or Location <i>Randallstown</i>		
			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>3704 Vega Road</i>		10f. Zip Code <i>21133</i>		10g. Citizen of What Country? <i>United States of America</i>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>District Manager</i>		16b. Kind of Business/Industry <i>Steamship</i>
17. Father's Name (First, Middle, Last) <i>John Edward Reed</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Emily F. Hull</i>	
19a. Informant's Name/Relationship (Type, Print) <i>Mrs Mary Louise Reed (Spouse)</i>				
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3704 Vega Road, Randallstown, Maryland 21133</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Lake View Memorial Park</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>21784</i>		Date <i>09/30/06</i>	20c. Location - City or Town, State <i>Sykesville, Maryland</i>
21. Signature of Funeral Service Licensee <i>Joseph J. Kellner 1007373</i>				
22. Name and Address of Facility <i>Loring Byers Funeral Directors, Inc 8728 Liberty Road, Randallstown, Maryland 21133</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Pancreatic Cancer</i>				
Approximate Interval Between Onset and Death <i>months</i>				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
{ a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <i>Subacute Unit</i>		
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>M</i>		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		<i>M</i>		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Christine Rajabi 5401 Old Court Road Randallstown Maryland</i>
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <i>Christine Rajabi Hospitalist</i>		29c. License number <i>62912</i>		29d. Date signed (Month, Day, Year) <i>September 25 2006</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
31. Date filed (Month, Day, Year) <i>SEP 28 2006</i>				
32. Registrar's Signature <i>Leanne L. Foster</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

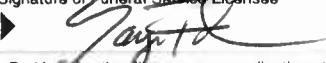
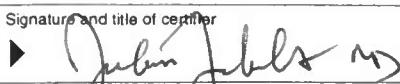
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30776

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVA RUDOVSKY</b>				2. Date of Death Month Day Year <b>SEPT. 26, 2006</b>	3. Time of Death 12:00A M		
	4a. Facility Name (If not institution, give street and number) <b>5906 PARK HEIGHTS AVENUE #504</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>213-94-9823</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month Day Year) <b>10/01/1918</b>	9. Birthplace (State or Foreign Country) <b>RUSSIA</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>BALTIMORE</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	10e. Street and Number <b>5906 PARK HEIGHTS AVENUE #504</b>			10f. Zip Code <b>21215</b>	10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>BOOKKEEPER</b>	16b. Kind of Business/Industry <b>ACCOUNTING</b>					
	17. Father's Name (First, Middle, Last) <b>ISRAEL</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>LERNER CHANA</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>GALYNASKY</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>GRIGORY RUDOVSKY / HUSBAND</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5906 PARK HEIGHTS AVENUE #504 - BALTIMORE, MD 21215</b>	Date 20c. Location - City or Town, State <b>REISTERSTOWN, MD</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>BALTIMORE HEBREW CEM</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW CEM</b>	20c. Location - City or Town, State <b>REISTERSTOWN, MD</b>					
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>LIVER CANCER</b>						Approximate Interval Between Onset and Death <b>3 months</b>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	a. _____ Due to (or as a consequence of): <b>LIVER CANCER</b>	b. _____ Due to (or as a consequence of): 	c. _____ Due to (or as a consequence of): 	d. _____ Due to (or as a consequence of): 				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <b>021039</b>				29d. Date signed (Month, Day, Year) <b>9/26/06</b>		
	29b. Signature and title of certifier  <b>JULIA STANZONI, MD</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TJYAN STANZONI, MD 2835 Smith Ave Baltimore MD 21208</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>	32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30777

Certificate of Death

Rag. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marguerite O. Shepherd</b>							2. Date of Death Month Day Year <b>September 27, 2006</b>	3. Time of Death 8:30 A M		
	4a. Facility Name (If not institution, give street and number) <b>2124 Beach Drive</b>				4b. City, Town, or Location of Death <b>Pasadena</b>			4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>213-12-2776</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan 27, 1921</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
	Usual Residence of Decedent 10a. State <b>Maryland</b>				10b. County <b>Anne Arundel</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10c. City, Town or Location <b>Pasadena</b>				10f. Zip Code <b>21122</b>			10g. Citizen of What Country? <b>USA</b>			
	10e. Street and Number <b>2124 Beach Drive</b>										
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>		16b. Kind of Business/Industry <b>Security</b>						
	17. Father's Name (First, Middle, Last) <b>George A. Steiner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Beattie I. Taylor</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Marguerite Bellman, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2124 Beach Drive Pasadena, Maryland 21122</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Thomas Gregor</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		Date <b>09/28/06</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>					
	21. Signature of Funeral Service Licensee <b>Thomas Gregor</b>				22. Name and Address of Facility <b>Cremation Society Of Maryland, Inc.</b> <b>299 Frederick Road Baltimore, Maryland 21228</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>METASTATIC CANCER OF SPINE</b>									Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <b>METASTATIC CANCER OF SPINE</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier <b>Surya Mondal MD</b>		29c. License number <b>D 21776</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 27, 2006</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SURYA MONDAL 3001 SHANOVER ST. BALTIMORE 21225</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Surya Mondal</b>								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30778

## Certificate of Death

Reg. No.

1- For  
State  
RegisterPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 7:40 AM	
		<b>JOSEPHINE SQUIRE</b>		09. 26. 2006			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
<b>GILCHRIST HOSPICE CENTER</b>		<b>TOWSON</b>		<b>BALTIMORE</b>			
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 10	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 09. 25. 1936	9. Birthplace (State or Foreign Country) NC
Usual Residence of Decedent		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10e. Street and Number <b>1514 SHEFFIELD ROAD</b>				10f. Zip Code 21218		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) <b>12TH GRADE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLAIMS AUTHORIZER</b>		16b. Kind of Business/Industry <b>SOCIAL SECURITY</b>			
17. Father's Name (First, Middle, Last) <b>GARLAND ROBERTSON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ROXIE BYNUM</b>					
19a. Informant's Name/Relationship (Type, Print) <b>CRYSTAL DUNN (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21 GREENBRUSH CT., BALTO. MD 21224</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		Date 10.03.06	20c. Location - City or Town, State <b>OWINGS MILLS, MD</b>
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229</b>					
21. Signature of Funeral Service Licensee 							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Leukemia				Approximate interval Between Onset and Death months	
b. Sequential fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of): Chemotherapy				months	
c.		Due to (or as a consequence of): Breast Cancer				years	
d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospital</b>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D 58303</b>		29d. Date signed (Month, Day, Year) <b>September 26 2006</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Milton Charles Dunn 6601 N. Charles St Baltimore MD 21204</b>		32. Registrar's Signature 					
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30779

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Emily Anna Schafer</b>							2. Date of Death Month      Day      Year <b>September 27, 2006</b>	3. Time of Death A.M.				
	4a. Facility Name (If not institution, give street and number) <b>Ridgeway Manor Nursing Home</b>			4b. City, Town, or Location of Death <b>Catonsville</b>			4c. County of Death <b>Baltimore</b>						
Funeral Director	5. Social Security Number <b>213-14-9023</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>SEP 24, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Catonsville</b>									10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>5743 Edmondson Avenue</b>			10f. Zip Code <b>21228</b>			10g. Citizen of What Country? <b>USA</b>						
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Assistant Branch Manager</b>			16b. Kind of Business/Industry <b>Savings &amp; Loan</b>						
	17. Father's Name (First, Middle, Last) <b>Jesse James Chamberlain</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Amelia Barnett</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>James W. Schafer/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>487 Heritage Drive Gettysburg, PA 17325</b>								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Edward A. Gregorchik</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		Date <b>10/7/06</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>					
	21. Signature of Funeral Service Licensee <b>► Edward A. Gregorchik</b>				22. Name and Address of Facility MacNabb Funeral Home, P.A. <b>301 Frederick Road Catonsville, MD 21228</b>								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Altered Cardiac Disease</i></b> Due to (or as a consequence of): <b>year</b>									Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. c. d.</b> Due to (or as a consequence of):												
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide										28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
										28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier <b>► Charles R. Graham Jr. M.D.</b>										29c. License number <b>D24781</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles R. Graham Jr. 1001 Pine Heights Ave #300 Baltimore, MD 21209</b>										29d. Date signed (Month, Day, Year) <b>September 28, 2006</b>			
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>										32. Registrar's Signature <b>Anna J. Gable</b>			

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be called at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30780

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Emma Lou Schwagel</b>						2. Date of Death Month Day Year <b>September 21 2006</b>	3. Time of Death 19:20 M
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>			4b. City, Town, or Location of Death <b>Hagerstown</b>			4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>429-14-1862</b>	6. Sex <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug 11, 1920</b>	9. Birthplace (State or Foreign Country) <b>Kansas</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Washington</b>			10c. City, Town or Location <b>Boonsboro</b>			10d. Inside City Limits <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>22 Mountain View Drive</b>			10f. Zip Code <b>21723</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>X</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>teacher</b>			16b. Kind of Business/Industry <b>education</b>		
	17. Father's Name (First, Middle, Last) <b>Glenn Edward Walden</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Davis</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara A. Widdicombe/niece</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2981 Bennett Charles Road Mt. Pleasant SC 29466</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>			22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Breast Cancer</b> Approximate Interval Between Onset and Death <b>12 years</b>							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Robert Brull MD Personal Physician</b>							
	29c. License number <b>D 0004359</b>							
	29d. Date signed (Month, Day, Year) <b>Sep 22 2006</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT BRULL 1459 POTOMAC ST. HAGERSTOWN, MD 21742</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Robert Brull</b>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28-a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2006 30781

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KAREN STEVENSON

2. Date of Death

Month Day Year  
September 17 2006 2:45 PM

3. Time of Death

ANNE ARUNDEL

4a. Facility Name (If not institution, give street and number)

BALTIMORE WASHINGTON MEDICAL CENTER

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

5. Social Security Number

579-82-3377

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

29 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

Oct 10, 1976

9. Birthplace (State or Foreign  
Country)

UNK

Funeral  
Director

KAREN . STEVENSON  
 Baltimore, Maryland 21215-0036  
 Permit Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or if Items 23a or 28a-f show  
 any injury or other traumatic event, the Medical Examiner must be notified at  
 once.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State DC

10b. County Washington

10d. Inside City Limits  
1  Yes 2  No

10e. Street and Number

4202 4th Street SE

10f. Zip Code

20032

10g. Citizen of What Country?  
USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced12. Was Decedent Ever in U.S.  unk1  Yes 2  No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1  Yes 2  No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: black15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
unkCollege (1-4 or 5+)  
unk16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Baltimore Washington Med Ctr

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 Hospital Drive Glen Burnie, MD 21061

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Acquired Immune deficiency Syndrome  
Due to (or as a consequence of):b. Dehydration  
Due to (or as a consequence of):c. Pneumonia  
Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1  Yes 2  No  
9  Unknown23c. If yes, outcome of pregnancy  
1  Live birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (specify)  
9  Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No26. Place of Death (Check only one)  
Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

27. Manner of Death

1  Natural 5  Pending investigation  
2  Accident 6  Could not be determined  
3  Suicide  
4  Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

M

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier

Admitting Physician

29c. License number

D44973

29d. Date signed (Month, Day, Year)

September 17 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
GURMEET S. SAWHNEY MD 325 Hospital Drive 202  
Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

SEP 28 2006

32. Registrar's Signature

KAREN S. STEVENSON

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30782  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY JANE SCHOM PORT</b>							2. Date of Death Month: <b>SEPT.</b> Day: <b>16<sup>TH</sup></b> Year: <b>2006</b>	3. Time of Death 4b. City, Town, or Location of Death: <b>Cumberland</b> 4c. County of Death: <b>Allegany</b>	
	4a. Facility Name (If not institution, give street and number) <b>New Hope Personal Care Asst Living</b>				4b. City, Town, or Location of Death: <b>Cumberland</b> 4c. County of Death: <b>Allegany</b>					
Funeral Director	5. Social Security Number <b>293-38-6350</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Aug 29, 1941</b>	9. Birthplace (State or Foreign Country) <b>Washington DC</b>			
Usual Residence of Decedent 10a. State: <b>MD</b> 10b. County: <b>Allegany</b> 10c. City, Town or Location: <b>Cumberland</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number <b>11609 Bierman Drive</b>				10f. Zip Code <b>21502</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1965</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 0</b>			unk			16b. Kind of Business/Industry unk		
17. Father's Name (First, Middle, Last) <b>Paul N. Smith</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Eidith Longstreth</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Daniel L. Smith/brother</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>236 School Street Bedford, PA 15522</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Ronald S. Wade, Director</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State			
21. Signature of Funeral Service licensee <b>Ronald S. Wade, Director</b>										
22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. END STAGE EMPHYSEMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Least <b>b. c. d.</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
Approximate Interval Between Onset and Death <b>5 yrs</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Robustiano J. Barrera, Jr.</b>					29c. License number <b>D-14865</b>			29d. Date signed (Month, Day, Year) <b>SEPT. 18<sup>TH</sup>, 2006</b>		
30. Name and address of person who completed cause of death (Item 2a) (Type, Print) <b>Robustiano Barrera (Robustiano), M.D.</b>										
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>James B. Speer</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust receipt.

Medical Certification: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

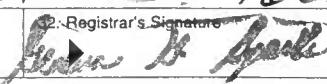
State of Maryland / Department of Health and Mental Hygiene

2006 30783

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William E. Seufert</b>							2. Date of Death Month <b>September</b> Day <b>26</b> , Year <b>2006</b>	3. Time of Death 11:00 pM
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Ruxton</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>218-10-7221</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Sept 18, 1920</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Lutherville</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>3 Tenbury Road</b>			10f. Zip Code <b>21093</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>W W II</b> If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Specify:</b>			14. Race - American Indian, Black, White, etc. <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (9-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Conductor</b>			16b. Kind of Business/Industry <b>Rail Road</b>		
	17. Father's Name (First, Middle, Last) <b>Anthony Seufert</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Engelke</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>James J. Kloiber-nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>402 Wrenleigh Dr., Catonsville, MD 21228</b>				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral</b>		Date <b>9/30/06</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>William G. Dau</b>				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc.</b> <b>1050 York Rd., Towson, MD 21204</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CEREBRAL HEMORRHAGE</b>							Approximate Interval Between Onset and Death <b>weeks.</b>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  { a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								
	23b. IF FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 		29c. License number <b>D-0012849</b>			29d. Date signed (Month, Day, Year) <b>9-27-06</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A.H. GHILADI, M.D. 7600 OSLER DR. TOWSON MD 21204</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2006 30784

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death				
	Betty Simms			September 21 2006	1145 A M							
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death					
	Augsburg Lutheran Nursing Home			Baltimore			N/A					
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 06 07 36	9. Birthplace (State or Foreign Country) MD					
	219-32-7375											
Usual Residence of Decedent												
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 3715 Coronado Road		10f. Zip Code 21244				10g. Citizen of What Country? U.S.A.						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4yrs			16b. Kind of Business/Industry Social Worker			Lockheed Martin			
17. Father's Name (First, Middle, Last) James Brown			18. Mother's Name (First, Middle, Maiden Surname) Roxanne Simms-Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3715 Coronado Road, Balto, Md 21244						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park			Date 9/27/06	20c. Location - City or Town, State Randallstown, Md					
21. Signature of Funeral Service Licensee Dwight B. Keke			22. Name and Address of Facility March F/H West			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death 6 months			
a. Due to (or as a consequence of): metastatic cancer to liver, primary unknown												
b. Due to (or as a consequence of):												
c. Due to (or as a consequence of):												
d. Due to (or as a consequence of):												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D37573			29d. Date signed (Month, Day, Year) September 21, 2006						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeff Rilell MD 25 Main St. Reisterstown MD 21136			32. Registrar's Signature Kean B. Spangler									
31. Date filed (Month, Day, Year) SEP 28 2006												

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23e or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached (or used as the burial-transit slip).

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30785

**1- For State Registrar****Physician Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1035 hrs
Davon Edward Sampson	September 26, 2006	

**Funeral Director**

4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death			
5. Social Security Number 219-17-5473	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs, last birthday) 18 Yrs.	If Under 1 Year Months Days Hours Min	8. Date of Birth (MM/DD/YYYY) 11 04 87	9. Birthplace (State or Foreign Country) MD

**To Be Completed by Funeral Director**

Baltimore, MD 21215-0036  
 Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10a. State MD	10b. County NA	10c. City, Town or Location Baltimore	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 3402 Alto Road		10f. Zip Code 21216	10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade	College (1-4 or 5+) na	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook	16b. Kind of Business/Industry Taco Bell
17. Father's Name (First, Middle, Last) Ronald Sampson		18. Mother's Name (First, Middle, Maiden Surname) Donna Brown	

19a. Informant's Name/Relationship (Type, Print) Willie Mae McCrae-Aunt	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Alto Road, Baltimore, Md 21216		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Ronald A. Thompson</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial	Date 10/3/06	20c. Location - City or Town, State Arbutus, Md

21. Signature of Funeral Service Licensee <i>Ronald A. Thompson</i>	22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, md 21215
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**Physician /Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial - transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
a. <b>Gunshot wound to abdomen</b> Due to (or as a consequence of):		
b. _____ Due to (or as a consequence of):		
c. _____ Due to (or as a consequence of):		
d. _____		
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	
IF FEMALE:	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
_____		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
_____		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Sep 26, 2006	28b. Time of Injury 0906 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) St. Ambrose St., Baltimore, Md.		

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
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29b. Signature and title of certifier <i>Zabiullah Ali, M.D.</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 27, 2006
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30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
31. Date filed (Month, Day, Year) SEP 28 2006	32. Registrar's Signature <i>James B. Spangler</i>

**State Registrar**

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30786

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Pauline Trogdon</b>					2. Date of Death Month Day Year <b>September 24, 2006</b>	3. Time of Death <b>12:13AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>			4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>212-32-5443</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>12-27-36</b>	9. Birthplace (State or Foreign Country) <b>N.C.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>NA</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
	10e. Street and Number <b>3605 Monterey Road</b>			10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates: <b>Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: Black</b>		14. Race - American Indian, Black, White, etc.			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 2 yrs. Accountant</b>		16b. Kind of Business/Industry <b>State of Md.</b>				
	17. Father's Name (First, Middle, Last) <b>Fred Lee Higgs</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Eartie Owens</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Mildred H. Knight Sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3605 Monterey Rd., Baltimore, Md. 21218</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Mt. Carmel Cem.</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)	Date <b>9-29-06</b>	20c. Location - City or Town, State <b>Dundalk, Md.</b>			
	21. Signature of Funeral Service Licensee <b>Joseph R. Walter Jr.</b>			22. Name and Address of Facility <b>March F.H. East 1101 E. North Ave., Baltimore, Md. 21202</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Breast Cancer</b> a. Due to (or as a consequence of): <b>Due to (or as a consequence of):</b> b. Due to (or as a consequence of): <b>Due to (or as a consequence of):</b> c. Due to (or as a consequence of): <b>Due to (or as a consequence of):</b> d.							Approximate Interval Between Onset and Death <b>YEARS</b>	
	23b. If female: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>D 12849</b>				29d. Date signed (Month, Day, Year) <b>9-24-06</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HAMID GHILADI, M.D., 7601 Osler Drive Towson, Maryland 21204</b>								
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature <b>Anna S. [Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial and transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 19a, per FH, G859, 9/28/06, WS

State of Maryland / Department of Health and Mental Hygiene

2006

30787

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death	3. Time of Death					
	Thelma M Thornton			Month	Day	Year	4 P M							
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death							
	Johns Hopkins Bayview Care Center			Baltimore			Baltimore City							
	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)		8. If Under 1 Year	9. If Under 24 Hrs.	10. Date of Birth	11. Birthplace (State or Foreign Country)					
	212-48-4972		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	58 Yrs.		Months	Days	Hours	Min.	Dec. 4, 1947	Maryland			
Usual Residence of Decedent														
	10a. State	10b. County		10c. City, Town or Location					10d. Inside City Limits					
	MD	Baltimore		Rosedale					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number				10f. Zip Code					10g. Citizen of What Country?					
8909 Talc Drive				21237					USA					
11. Marital Status				12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify:				
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white			white				
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry							
Elementary/Secondary (0-12) 12				College (1-4 or 5+)			Homemaker			Home				
17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Surname)								
George Salisbury						Mary Daniels								
19a. Informant's Name/Relationship (Type, Print)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Thornton Ross Thornton - Husband						8909 Talc Drive Rosedale, MD 21237								
20a. Method of Disposition						20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State				
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) MacLeod						Metro Crematory			Sep. 27, 06	Baltimore, MD				
21. Signature of Funeral Service Licensee						22. Name and Address of Facility								
► W.B. MacLeod						Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
Approximate Interval Between Onset and Death														
Immediate Cause (Final disease or condition resulting in death) <i>Arhythmia</i> minutes														
Sequentially list conditions, injury leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>End stage Renal Disease</i> years														
c. <i>Hemodialysis</i>														
d.														
IF FEMALE:		23c. If yes, outcome of pregnancy			3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)			23d. Date of delivery						
23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 9 <input type="checkbox"/> Unknown							Month	Day	Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
<i>Diabetes mellitus</i>														
<i>Coronary Artery Disease</i>														
<i>Stage IV scrotal wound</i>														
25. Was case referred to medical examiner?		26. Place of Death (Check only one)												
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death		28a. Date of Injury (Month, Day Year)			28b. Time of Injury			28c. Injury at Work?			28d. Describe how injury occurred			
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
29a. Certifier (Check only one)		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)			
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier											29d. Date signed (Month, Day, Year)			
► W.B. Greenough MD											September 25 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)														
W.B. Greenough MD 5505 Hopkins Bayview Circle Balt, MD 21224														
31. Date filed (Month, Day, Year)		32. Registrar's Signature												
SEP 28 2006		► Sean H. Spak												

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, ► A Medical Examiner must be utilized.

**Baltimore, MD 21215-0036**

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Division of Vital Records, P.O. Box 68760,**  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

**Please Type or Print in Black Indelible Ink****State of Maryland / Department of Health and Mental Hygiene****Certificate of Death**

Reg. No.

2006 30788

**1- For State Registrar****Physician/****Medical Examiner****Funeral Director****To Be Completed by Funeral Director****Medical Certification: To Be Completed by Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year September 23, 2006			3. Time of Death 2042 hrs		
Robert Lee Thieler							
4a. Facility Name (if not institution, give street and number) 3616 Coolidge Avenue			4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A	
5. Social Security Number 213-80-3848	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months	If Under 24 Hrs Days	8. Date of Birth (MM/DD/YYYY) FEB 20, 1961	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent Maryland N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3616 Coolidge Avenue			10f. Zip Code 21229			10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: White				14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Diesel Mechanic			16b. Kind of Business/Industry Auto Repair		
17. Father's Name (First, Middle, Last) Jürgen Horst Thieler			18. Mother's Name (First, Middle, Maiden Surname) Ethel Courtney DeBus				
19a. Informant's Name/Relationship (Type, Print) Carey Smith/Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3629 Clarenell Road Baltimore, MD 21229					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Edward A. Gregorchik	20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.	Date 9/30/06	20c. Location - City or Town, State Baltimore, MD				
21. Signature of Funeral Service Licensee Edward A. Gregorchik		22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
a. Contact Gunshot Wound of Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) FOUND: Sep 23, 2006		28b. Time of Injury FOUND: 2030 hrs		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3616 Coolidge Avenue, Baltimore, MD		28d. Describe how injury occurred Subject shot self	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Patricia Aronica-Pollak					
		29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) September 24, 2006		
30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner		111 Penn Street, Baltimore, MD 21201					
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature Lorraine H. Pollak					

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30789

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or if Items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
<i>Donald Taylor</i>		<i>September 9 2006</i>				<i>0750 AM</i>	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
<i>University of Maryland Medical Ctr.</i>		<i>Baltimore</i>					
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>45</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>Feb 19, 1961</i>	9. Birthplace (State or Foreign Country) <i>unk</i>
Usual Residence of Decedent		10a. State <i>MD</i> 10b. County <i>MD</i> 10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>4809 Homer Avenue</i>		10f. Zip Code <i>21215</i>				10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>unk</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>unk</i>		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) unk</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+) unk</i>		16b. Kind of Business/Industry <i>unk</i>		unk	
17. Father's Name (First, Middle, Last) <i>unk</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>unk</i>				unk	
19a. Informant's Name/Relationship (Type, Print) <i>University of Md Med Ctr</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>22 S. Greene Street Baltimore, MD 21201</i>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>in state</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>unk</i>		20c. Location - City or Town, State <i>unk</i>		Date	
21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>		22. Name and Address of Facility <i>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death					
<p>a. <i>uremia</i> Due to (or as a consequence of):</p> <p>b. <i>renal failure</i> Due to (or as a consequence of):</p> <p>c. <i>metastatic squamous cell cancer</i> Due to (or as a consequence of):</p> <p>d.</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>unk</i>				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial fibrillation</i>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>P 19858</i>				29d. Date signed (Month, Day, Year) <i>September 9 2006</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		32. Registrar's Signature <i>James B. Steele</i>				31. Date filed (Month, Day, Year) <i>SEP 28 2006</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30790

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 26e-f show any injury or other traumatic event, the Medical Examiner must be notified at all times.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year			3. Time of Death		
<i>Robert</i>			<i>Truscott</i> September 15, 2006			14:40 PM		
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
<i>The Johns Hopkins Hospital</i>			<i>Baltimore</i>					
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan 16, 1954		9. Birthplace (State or Foreign Country) unk
215-58-3638								

Funeral  
Director

To Be Completed by Funeral Director

10a. State MD	10b. County Harford	10c. City, Town or Location Aberdeen	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1862 Perryman Road		10f. Zip Code 21001	10g. Citizen of What Country? USA
11. Marital Status unk	12. Was Decedent Ever in U.S. Armed Forces? unk <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) unk	16b. Kind of Business/Industry unk
17. Father's Name (First, Middle, Last) Johns Hopkins Hospital		unk	18. Mother's Name (First, Middle, Maiden Surname) unk
19a. Informant's Name/Relationship (Type, Print) Johns Hopkins Hospital		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 N. Wolfe Street Baltimore, MD 21287	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date
21. Signature of Funeral Service Licensee <i>Ronald S. Wade Director</i>		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequential fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
<p>a. <i>Metastatic Lung Cancer</i> Due to (or as a consequence of):</p> <p>b. <i>Urinary tract Infection</i> Due to (or as a consequence of):</p> <p>c. <i>Septic Shock</i> Due to (or as a consequence of):</p> <p>d. _____</p>			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	
23d. Date of delivery Month Day Year			

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>RES-000</i>			
29b. Signature and title of certifier <i>Ronald S. Wade</i>		29d. Date signed (Month, Day, Year) <i>September 19, 2006</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Emilie JBCarvello 600 N. Wolfe St. Baltimore, Maryland 21287</i>					
31. Date filed (Month, Day, Year) <i>SEP 28 2006</i>		32. Registrar's Signature <i>Susan B. Smith</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

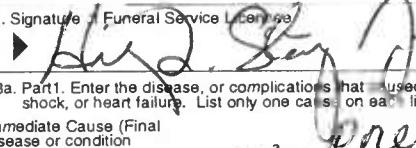
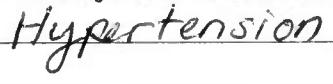
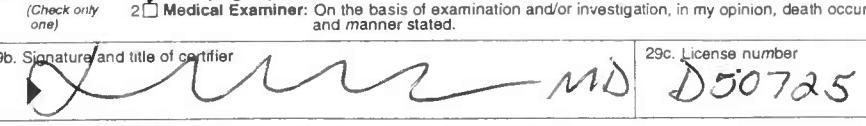
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30791

1- For  
State  
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosalie H Taber				2. Date of Death Month Day Year September 21 2006	3. Time of Death 10AM M
	4a. Facility Name (If not institution, give street and number) Future Care		4b. City, Town, or Location of Death Arnold		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 216-32-4814	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min. If Yes, Give Year or Dates:	8. Date of Birth (Month, Day, Year) DEC 16 1918	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State Maryland				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10b. County Anne Arundel		10c. City, Town or Location Pasadena		10g. Citizen of What Country? USA	
	10e. Street and Number 248 Hickory Point		10f. Zip Code 21122			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Household		16b. Kind of Business/Industry Homemaker	
	17. Father's Name (First, Middle, Last) Eugene		Dove		18. Mother's Name (First, Middle, Maiden Surname) Rosalie Watson	
	19a. Informant's Name/Relationship (Type, Print) Suzanne Fair daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 248 Hickory Point Road Pasadena MD 21122			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery		Date 9/25/06	20c. Location - City or Town, State Annapolis Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena Maryland 21122			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.  Due to (or as a consequence of): pneumonia				Approximate Interval Between Onset and Death days	
	b. Due to (or as a consequence of):					
	c. Due to (or as a consequence of):					
	d. _____					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number MD D50725			
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 9-21-2006			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Riedinger 8601 Veterans Hwy Millersville MD 21108					
	31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30792

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHNNIE THOMPSON</b>							2. Date of Death Month Day Year <b>SEPT 25 2006</b>	3. Time of Death <b>110 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL</b>			4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>			4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>220-20-3327</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>Sep 4, 1929</b>	9. Birthplace (State or Foreign Country) <b>Florida</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b>				10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>306 Lyndhurst Street</b>				10f. Zip Code <b>21229</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <b>Black</b> Specify:	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (9-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>	
	17. Father's Name (First, Middle, Last) <b>Fred Wright Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Essie Mae Scott</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Catherine Thompson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>116 Tennyson Court Abingdon, Maryland 21009</b>			Date <b>10/04/06</b>	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Casket</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore National Cemetery</b>			20c. Location - City or Town, State <b>Baltimore, Md.</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Carl J. Estep SP</b>				22. Name and Address of Facility <b>Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ACUTE MYOCARDIAL INFARCTION</b>							Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>								
	b. Due to (or as a consequence of): <b>DIABETES MELLITUS</b>								
	c. Due to (or as a consequence of): <b>Obesity</b>								
	d. Due to (or as a consequence of): <b>Hypertension</b>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>Unknown</b>			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>5401 OLD COURT RD RANDALLSTOWN MD 21133</b>			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D58933</b>			29d. Date signed (Month, Day, Year) <b>SEPT 25, 2006</b>			
	29b. Signature and title of certifier <b>KERITA JOSEPH</b>		29e. Registrar's Signature <b>James B. Jones</b>						
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importantly: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importantly: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30793

Reg. No.

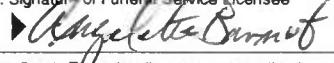
1-  
For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Mary-Elizabeth Tryon</b>							2. Date of Death Month Day Year <b>September 25, 2006</b>	3. Time of Death 6:00 A M	
4a. Facility Name (If not institution, give street and number) <b>6008 Namakagan Road</b>				4b. City, Town, or Location of Death <b>Bethesda</b>			4c. County of Death <b>Montgomery</b>		
5. Social Security Number <b>578-40-0976</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>April 23, 1924</b>	9. Birthplace (State or Foreign Country) <b>Ohio</b>

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Usual Residence of Decedent			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Bethesda</b>						
10e. Street and Number <b>6008 Namakagan Road</b>			10f. Zip Code <b>20816</b>			10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2		16b. Kind of Business/Industry Homemaker				
17. Father's Name (First, Middle, Last) <b>Edward Eliot Green</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lottie Mae Rothmyer</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Max Tryon / Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6008 Namakagan Road, Bethesda, Maryland 20816</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		Date <b>September</b>	20c. Location - City or Town, State <b>Bethesda, Maryland</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.</b> <b>7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>						

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>15 Years</b>
{		a. Lymphoma Due to (or as a consequence of):	b. _____ Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):
{		d. _____		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No

25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <b>D51616</b>	29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nelson Kalil, M.D. 5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815</b>	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>	32. Registrar's Signature 
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30794

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lucille S. Taylor</b>							2. Date of Death Month Day Year <b>September 25, 2006</b>	3. Time of Death <b>6:55 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3004 N. Ridge Road #404</b>			4b. City, Town, or Location of Death <b>Ellicott City</b>			4c. County of Death <b>Howard</b>			
Funeral Director	5. Social Security Number <b>212-01-6241</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>94 Yrs.</b>	If Under 1 Year Months <b> </b>	If Under 24 Hrs. Hours <b> </b>	8. Date of Birth (Month, Day, Year) <b>June 29, 1912</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Howard</b>			10c. City, Town or Location <b>Ellicott City</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>3004 N. Ridge Road #404</b>			10f. Zip Code <b>21043</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates: 			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: 			14. Race - American Indian, Black, White, etc. <b>Specify: white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Law</b>			
	17. Father's Name (First, Middle, Last) <b>Wilmer Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Estelle Hook</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Cremen</b> <b>Niece</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6827 Ridge Road; Marriottsville, MD 21104</b>						
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>			Date <b>9/28/2006</b>	20c. Location - City or Town, State <b>Pikesville, MD</b>		
	21. Signature of Funeral Service Licensee <b>Bernard J. Salcedo</b>			22. Name and Address of Facility <b>Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc.</b> <b>1630 Edmondson Avenue; Catonsville, MD 21228</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 M</b>	
	a. <b>Congestive Heart Failure</b> Due to (or as a consequence of): <b>Severe Chronic Obstructive Lung Disease</b>									
	b. Due to (or as a consequence of): <b>Peripheral Vascular Disease</b>								5 years	
	c. Due to (or as a consequence of): <b>Coronary Artery Disease</b>								1 years	
	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>								23d. Date of delivery Month Day Year	
	23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fatal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>	
									24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>							
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day Year) <b> </b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b> </b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b> </b>				
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29c. License number <b>D13671</b>						29d. Date signed (Month, Day, Year) <b>9-27-06</b>	
	29b. Signature and title of certifier <b>► M. Manejwala</b>		29c. Registrar's Signature <b>► James B. G. Manejwala</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>B.G. Manejwala, M.D.</b>		31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>						32. Registrar's Signature <b>► James B. G. Manejwala</b>	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30795

1- For  
State  
Register

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28-a show any injury or other traumatic event, the Medical Examiner shall be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Year	3. Time of Death Hour Minute
MIRACLE UDUIJI							09 15 2006	1248 AM
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
HOLY CROSS HOSPITAL			SILVER SPRING			MONTGOMERY		
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 09 14 2006	9. Birthplace (State or Foreign Country) MARYLAND	
none				4	30			
Usual Residence of Decedent								
10a. State MD	10b. County PG	10c. City, Town or Location RIVERDALE						
10e. Street and Number 6803 BEACON LIGHT RD				10f. Zip Code 20737			10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) none		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none		16b. Kind of Business/Industry none				
17. Father's Name (First, Middle, Last) BENJAMIN UDUIJI				18. Mother's Name (First, Middle, Maiden Surname) NKIRU UDUIJI				
19a. Informant's Name/Relationship (Type, Print) HOLY CROSS HOSPITAL				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 FOREST GLEN RD SILVER SPRING MD 20910				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) none		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<p>a. Prematurity 22 WEEKS GEST Due to (or as a consequence of):</p> <p>b. RESPIRATORY DISTRESS Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown						
23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INCOMPETENT CERVIX - MATERNAL								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 					29c. License number H64286		29d. Date signed (Month, Day, Year) 09/15/10	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEHA GREENSPAN MD 1500 FOREST GLEN RD SILVER SPRING MD 20910								
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature 						

ORIGINAL

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No.

2006 30796

**1- For State Registrar****Physician/  
Medical Examiner****Funeral  
Director****Baltimore, MD 21215-0036**

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene

**Physician  
/Medical  
Examiner**

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30797

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Orville W. Wright							2. Date of Death Month 09 Day 20 Year 2006	3. Time of Death 10:33 am	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 195-18-9183	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) April 14, 1924	9. Birthplace (State or Foreign Country) Pennsylvania			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Parkville 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	10e. Street and Number 8830 Walther Blvd., Apt. 213				10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager			16b. Kind of Business/Industry Railroad			
	17. Father's Name (First, Middle, Last) David W. Wright				18. Mother's Name (First, Middle, Maiden Surname) Jane Moorhouse					
	19a. Informant's Name/Relationship (Type, Print) P. Jean Wright-wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8830 Walther Blvd., Apt. 213, Parkville, MD 21234					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Vet., Garrison Forest		Date 9/26/06	20c. Location - City or Town, State Owings Mills, MD		
	21. Signature of Funeral Service Licensed				William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
Medical Certification: To Be Completed by Physician/Medical Examiner	a. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of):									
	b. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D 58646					
	29b. Signature and title of certifier Anne Monicas				29d. Date signed (Month, Day, Year) September 22 2006					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Monicas 8830 Walther Boulevard Parkville, MD 21234				31. Date filed (Month, Day, Year) SEP 28 2006					
State Registrar	32. Registrar's Signature Anne B. Appler									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30798

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>Delmar Jacob Wood</b>		2. Date of Death Month <b>September</b> Day <b>24</b> , Year <b>2006</b>		3. Time of Death <b>10:30 a m</b>
4a. Facility Name (If not institution, give street and number) <b>1199 Hanson Road</b>		4b. City, Town, or Location of Death <b>Edgewood</b>		4c. County of Death <b>Harford</b>
5. Social Security Number <b>225-18-6933</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>X</b>	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>Oct. 29, 1920</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		
10a. State <b>Md.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Churchville</b>
10e. Street and Number <b>3210 Whitefield Road</b>		10f. Zip Code <b>21028</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>service engineer</b>		16b. Kind of Business/Industry <b>electrical and marine equipment</b>
17. Father's Name (First, Middle, Last) <b>Forrest Wood</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Effie (unknown)</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Linda Cisco/daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3210 Whitefield Road, Churchville, Md. 21028</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Gardens of Faith Cem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		Date <b>9/29/06</b>
21. Signature of Funeral Service Licensee <b>► Stefanie Rineker</b>		22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc.</b> <b>610 W. MacPhail Road, Bel Air, Md. 21014</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PROSTATIC CANCER</b> <b>HYPERTENSION, ESSENTIAL</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 5. Other (specify) <b>3 months</b>		
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
23f. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		
29b. Signature and title of certifier <b>► Rev. John C. Valasco</b>		29c. License number <b>D0016389</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 25, 2006</b>
30. Name and address of person cause of death (Item 23a) (Type, Print) <b>PETERECTO C. VALASCO, N.D. 1716 HARTFORD ROAD SU. 105 FALLSTON MD 21047</b>		32. Registrar's Signature <b>James B. Gandy</b>		
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		33. Date signed (Month, Day, Year)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
 amend Item 5 per fb 8860 10-5-06 vt  
 State of Maryland / Department of Health and Mental Hygiene

2006 30799

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or Items 23a or 26-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		Williams		2. Date of Death Month Day Year	3. Time of Death
Muriel				September 23 2006	18:03 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
The Johns Hopkins Hospital		Baltimore		N/A	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 05/06/1954
16 219-62-1444					9. Birthplace (State or Foreign Country) MD
Usual Residence of Decedent					
10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 924 Ashburton St.		10f. Zip Code 21216		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Years	16b. Kind of Business/Industry Office Manager			18. Mother's Name (First, Middle, Maiden Surname) Ruth Oliver
17. Father's Name (First, Middle, Last) Nathaniel Washington		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Bethou James Place, Baltimore, MD 21207			
19a. Informant's Name/Relationship (Type, Print) Duane L. Whitley (Son)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Cemetery		20c. Location - City or Town, State Baltimore, MD	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		22. Name and Address of Facility Vaughn C. Greene Funeral Svc 5157 Balto Nati Pk, Baltimore MD 21229			
21. Signature of Funeral Service Licensee ► Vaughn C Greene		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
<p>a. Intracranial Hemorrhage Due to (or as a consequence of):</p> <p>b. Acute Respiratory Distress Syndrome Due to (or as a consequence of):</p> <p>c. Sepsis Due to (or as a consequence of):</p> <p>d. Brain metastasis</p>				Approximate Interval Between Onset and Death 1 day 3 days 3 days 1 month	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung Cancer					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number OP19513		29d. Date signed (Month, Day, Year) September 23, 2006	
29b. Signature and title of certifier ► Parastoo Fazeli, MD					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parastoo Fazeli, The Johns Hopkins Hospital, 601 Wolfe Street, Baltimore, MD, 21287					
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature Jane B. Fazeli			

ORIGINAL

Division of Vital Records, P.O. Box 68760, &

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30800  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRIS J. WEBER</b>							2. Date of Death Month Day Year <b>SEPTEMBER 24 2006</b>	3. Time of Death Hour Min AM PM <b>4:00 M</b>
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>				4b. City, Town, or Location of Death <b>Randallstown</b>			4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>227-18-9600</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>March 28, 1924</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b>				10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Reisterstown</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>12020 Reisterstown Road</b>				10f. Zip Code <b>21136</b>			10g. Citizen of What Country? <b>United States of America</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>0</b> <b>Home Maker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>William Zachary Long</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Vera Pace</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Carol L. Greenwalt (Daughter)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3301 Elmo Drive, Randallstown, MD. 21133</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Woodlawn Cemetery</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		Date <b>09/27/06</b>	20c. Location - City or Town, State <b>Woodlawn, Maryland 21207</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc 8728 Liberty Road, Randallstown, Maryland 21133</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death				
a. <b>END STAGE MULTIPLE SCLEROSIS</b> Due to (or as a consequence of):									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) <b>8/24/06</b> 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133</b>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29b. Signature and title of certifier  <b>JOBINDER P MEHTA MD</b>								29c. License number <b>D41410</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOBINDER P MEHTA</b>								29d. Date signed (Month, Day, Year) <b>September 24, 2006</b>	
31. Date filed (Month, Day, Year) <b>SEP 28 2005</b>				32. Registrar's Signature  <b>JOBINDER P MEHTA</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#9, per H.659, 9/28/06 MS

State of Maryland / Department of Health and Mental Hygiene

2006

30801

1- For State Registrar		Certificate of Death																	
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death								
	MORRISON WHEELER							SEPTEMBER 24 2006			10:55A M								
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death											
	HARBOR HOSPITAL CENTER			BALTIMORE				BALTIMORE MD											
Usual Residence of Decedent		5. Social Security Number		6. Sex		7. Age (In yrs. last birthday)		If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)					
		214-44-7014		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		60 Yrs.		Months		Days		Hours		Min.		AUGUST 15 1946		MD	
10a. State		10b. County		10c. City, Town or Location								10d. Inside City Limits							
MD		Baltimore		Lansdowne								<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number		10f. Zip Code								10g. Citizen of What Country?									
2824 Huffman Avenue		21227								U.S.A.									
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.									
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 71-72				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				<input type="checkbox"/> white									
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								16b. Kind of Business/Industry									
Elementary/Secondary (0-12) 12		Gas Fitter								Baltimore Gas & Electric									
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)																	
Clinton Pete Wheeler		Frances Anna Hooker																	
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)																	
Helen C. Wheeler/Wife		2824 Huffman Avenue Baltimore MD 21227																	
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)				20c. Location - City or Town, State													
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		West Arundel Crematory 9-29-2006 Odenton, Maryland																	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227																	
Samuel J. Daugherty																			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death									
Immediate Cause (Final disease or condition resulting in death)		ASYSTOLE																	
Societally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		RESPIRATORY FAILURE																	
{		Due to (or as a consequence of):																	
a.		Due to (or as a consequence of):																	
b.		Due to (or as a consequence of):																	
c.		Due to (or as a consequence of):																	
d.																			
IF FEMALE:		23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy				23d. Date of delivery											
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				Month Day Year											
25. Was case referred to medical examiner?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital:		26. Place of Death (Check only one)		23e. Did tobacco use contribute to the cause of death?											
27. Manner of Death		Natural Accident Suicide Homicide		Pending investigation Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred							
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						M		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
29a. Certifier (Check only one)		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)							
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier		29c. License number								29d. Date signed (Month, Day, Year)									
John Kotzarth MD		RES001								SEPTEMBER 24 2006									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)																	
JOHN KOTZARTH MD, HARBOR HOSPITAL CENTER, BALTIMORE MD		SEP 28 2006																	
32. Registrar's Signature		33. Original																	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner shall be notified at

State Registrar

06-07163

Christopher Aaron Williams

**Please Type or Print in Black Indelible Ink**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2006 30802

1- For State  
Registrar**Physician/  
Medical Examiner****Funeral  
Director**

1. Decedent's Name (First, Middle, Last) <b>Christopher Aaron Williams</b>				2. Date of Death Month Day Year <b>September 23, 2006</b>			3. Time of Death 0036 hrs	
4a. Facility Name (if not institution, give street and number) <b>Shock Trauma</b>				4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>	
5. Social Security Number <b>217-06-8840</b>		6. Sex <b>1 [X] M 2 [ ] F</b>	7. Age (In yrs last birthday) <b>22 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (MM/DD/YYYY) <b>May 11, 1984</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
10a. State <b>Md.</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>			10d. Inside City Limits <b>1 [ ] Yes 2 [X] No</b>	
10e. Street and Number <b>125 Arundel Rd.</b>				10f. Zip Code <b>21122</b>			10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 [ ] Yes 2 [X] No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 [ ] Yes 2 [X] No</b>			14. Race - American Indian, Black, White, etc. <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>			16b. Kind of Business/Industry <b>Auto</b>	
17. Father's Name (First, Middle, Last) <b>Wayne Webber</b>				18 Mother's Name (First, Middle, Maiden Surname) <b>Marie Stevens</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marie Williams (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>125 Arundel Rd. Pasadena, Md. 21122</b>				
20a. Method of Disposition <b>1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other Specify:</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>		Date <b>9/27/06</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>	
21. Signature of Funeral Service [see]				22. Name and Address of Facility <b>Stallings Funeral Home PA 3111 Mountain Rd, Pasadena, Md. 21122</b>				

23a. Part I. Enter the disease, disorder, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 [ ] Yes 2 [ ] No 9 [ ] Unknown</b>		23c. If yes, outcome of pregnancy <b>1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (Specify) 9 [ ] Unknown</b>						23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <b>1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown</b>	
								24a. Was an autopsy performed? <b>1 [X] Yes 2 [ ] No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 [X] Yes 2 [ ] No</b>
25. Was case referred to medical examiner? <b>1 [X] Yes 2 [ ] No</b>		26 Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other							
27. Manner of Death <b>1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>Sep 22, 2006</b>		28b. Time of Injury <b>2242 hrs</b>	28c. Injury at Work? <b>1 [ ] Yes 2 [X] No</b>	28d. Describe how injury occurred <b>Driver auto fixed object collision</b>			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. <b>(Specify) Street</b>					28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2400 Hawkins Point Rd., Baltimore, MD</b>		

29a. Certifier (Check only one) <b>1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated</b>							
---	--	--	--	--	--	--	--

29b. Signature and title of certifier <b>Patricia Aronica-Pollak MD. Assistant Medical Examiner</b>				29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>September 23, 2006</b>
30. Name and address of person who completed cause of death (Item 23a) <b>Patricia Aronica-Pollak MD. Assistant Medical Examiner</b>		111 Penn Street, Baltimore, MD 21201					
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>[Signature]</b>					

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

Within 24 hours after death

After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial - transit

State  
RegistrarDHMH 17 Rev 1/2001  
OCME 2006

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30803  
Reg. No.1- For  
State  
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eula P. West</b>							2. Date of Death Month Day Year <b>Sep 24, 2006</b>	3. Time of Death 8:15 a M
	4a. Facility Name (If not institution, give street and number) <b>Elesy Manor Assisted Living</b>				4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>244-20-3825</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct 18, 1918</b>	9. Birthplace (State or Foreign Country) <b>No. Carolina</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b>				10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Randallstown</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>3724 Live Oak Avenue</b>				10f. Zip Code <b>21133</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>James Tucker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Susie Tucker</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Loretta Wainwright Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3724 Live Oak Avenue Randallstown, Maryland 21133</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Eugene X. Wallace</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Mem. Park</b>			Date <b>9/29/2006</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee <b>Eugene X. Wallace</b>				Name and Address of Facility <b>Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death <b>3 YEARS</b> <b>20 YEARS</b> <b>40 YEARS</b>		
a. <b>MULTI INFARCT DEMENTIA</b> Due to (or as a consequence of):				b. <b>ATHEROSCLEROSIS</b> Due to (or as a consequence of):					
c. <b>HYPERTENSION</b> Due to (or as a consequence of):				d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA, IRON DEFICIENCY</b> <b>CHRONIC RENAL FAILURE</b> <b>HYPERCHOLESTEROLEMIA</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>RAMANA GOPACAN</b>		29c. License number <b>D 51228</b>		29d. Date signed (Month, Day, Year) <b>9/26/2006</b>			
30. Name _____ address of person to whom completed clause of death Item 2a (Type, Print) <b>RAMANA GOPACAN MD 2801 LEBOWINE X205 #159 BALTIMORE 21228</b>		31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Jane B. Gandy</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

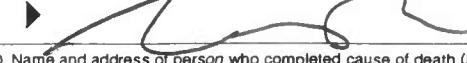
State of Maryland / Department of Health and Mental Hygiene

2006 30804

## Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	Edgar H. Walker							September 25, 2006	5:30 PM M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	Suburban Hospital			Bethesda			Montgomery		
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
	579-30-1217		77			March 2, 1929	Washington, D.C.		
Usual Residence of Decedent									
Maryland	Montgomery	North Bethesda						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State 10b. County				10c. City, Town or Location					
10e. Street and Number 6002 Neilwood Drive				10f. Zip Code 20852				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951 - 1953		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry President & Owner			16c. Kind of Business/Industry Printing Supply Company		
17. Father's Name (First, Middle, Last) William Worth Walker					18. Mother's Name (First, Middle, Maiden Surname) Mary Lou Howell				
19a. Informant's Name/Relationship (Type, Print) June Walker/ Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6002 Neilwood Drive, North Bethesda, Maryland 20852				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park			Date September 29, 2006	20c. Location - City or Town, State Rockville, Maryland		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure									
Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
b. Renal Failure Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number D61772				29d. Date signed (Month, Day, Year) September 26, 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TUNG DAO, M.D. 6410 Rockledge Drive #200 Bethesda, Maryland 20814									
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature 							

**Physician/  
Medical Examiner**

**Funeral  
Director**

Baltimore, MD 21215-0036

Important: If item 25 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**State  
Registrar**

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Amend 7/17/10 Per 1H 6853/09/07 JH

2006 30805

Reg. No.

1. For State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>BLANCA EDIS PORTILLO ZUNIGA</b>				2. Date of Death Month Day Year <b>September 23, 2006</b>		3. Time of Death 2331 hrs	
4a Facility Name (if not institution, give street and number) <b>St. Agnes Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
5. Social Security Number <b>UN</b>		6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>		7. Age (In yrs. last birthday) <b>27 Yrs.</b>		If Under 1 Year Months Days Hours Min. <b>0 0 0 0</b>	
8. Date of Birth (MM/DD/YYYY) <b>May 4</b>		9. Birthplace (State or Foreign Country) <b>EL SALVADOR</b>		10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			
10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>BALTIMORE</b>		10g. Citizen of What Country? <b>EL SALVADOR</b>	
10e. Street and Number <b>2017 ST. PAUL ST.</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>EL SALVADOR</b>	
11. Marital Status <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No specify EL SALVADOR</b>		14. Race - American Indian, Black, White, etc. <b>Specify: WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12TH</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>HOME</b>			
17. Father's Name (First, Middle, Last) <b>Benjamin FELIX BENJAMIN PORTILLO</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elena MARIA ZUNICA Maria Elena Zuniga</b>			
19a. Informant's Name/Relationship (Type, Print) <b>ANNA ZAMORA</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2603 CARROLL ST., BALTIMORE, MD 21230</b>					
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SAN LUIZ DELA RIVA</b>		Date <b>10-4-06</b>		20c. Location - City or Town, State <b>SAN SALVADORE</b>	
21. Signature of Funeral Service Licensee <b>Wesley Chavis</b>				22. Name and Address of Facility <b>WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 21231</b>			
23a. Please Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. <b>Cardiac arrhythmia</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death	
		b. _____ Due to (or as a consequence of):					
		c. _____ Due to (or as a consequence of):					
d. _____							
<b>X UNPENDED</b>		<b>X AMENDED 8 per fh g859 9-28-06 vt/ #18 per fh, G865, 3/13/07 TT #23a,27,perME,g861,11/14/06 TT // Amend item#1, perME</b>					
23b. Was decedent pregnant in the past 12 months? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input checked="" type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>				23d. Date of delivery Month Day Year <b>Apr 24, 2006</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>							
24a. Was an autopsy performed? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>					
25. Was case referred to medical examiner? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:		26. Place of Death (Check only one)			
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
						28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated</b>							
29b. Signature and title of certifier <b>Ling Li, MD</b>		29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>September 24, 2006</b>	
30. Name and address of person who completed cause of death (Item 23a) <b>Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>							
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>[Signature]</b>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30806

Reg. No.

1-  
For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: Item 27 is marked other than "natural", or Items 28a or 28a-1 show any injury or other traumatic event. The Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

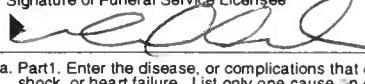
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

09-22-2006  
8:52 AM

State  
Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 9 Day 22 Year 2006				3. Time of Death 8:52 A M	
BAD JUN ZHOU							
4a. Facility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery	
5. Social Security Number 579-06-2458		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) December 4, 1920	9. Birthplace (State or Foreign Country) China
Usual Residence of Decedent							
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Rockville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 5907 Halsey Road			10f. Zip Code 20851			10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Chinese/Asian
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Master Carpenter		16b. Kind of Business/Industry Construction			
17. Father's Name (First, Middle, Last) Chai Gao Zhou				18. Mother's Name (First, Middle, Maiden Surname) Ai Yuen Lu			
19a. Informant's Name/Relationship (Type, Print) Zeng Hua Zhou / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5907 Halsey Road, Rockville, Maryland 20851			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date September 26, 2006		20c. Location - City or Town, State Silver Spring, Maryland	
21. Signature of Funeral Service Licensee 							
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Lung cancer							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. _____							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier 				29c. License number D62949		29d. Date signed (Month, Day, Year) 9/22/06	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natasha Haag 8600 Old Georgetown Road, Bethesda, Maryland 20814							
31. Date filed (Month, Day, Year) SEP 28 2006		32. Registrar's Signature 					

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2006 30807

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	Wilma W.	Arrington	2. Date of Death Month Day Year	3. Time of Death
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	4c. County of Death	
WMHS - Braddock Campus		Cumberland	Allegany	
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
214-05-4022				
4. Usual Residence of Decedent				
10a. State MD	10b. County Allegany	10c. City, Town or Location Cumberland		
10e. Street and Number 229 Baltimore Avenue, Apt #410		10f. Zip Code 21502	10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		
17. Father's Name (First, Middle, Last) Thornton Ellsworth		18. Mother's Name (First, Middle, Maiden Surname) Poole Margaret Ann Iser		
19a. Informant's Name/Relationship (Type, Print) David Arrington / son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1516 E. Oldtown Road, Apt A., Cumberland, MD 21502		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Mem. Park	Date 09/21/2006	20c. Location - City or Town, State Cumberland, MD
21. Signature of Funeral Service Licensee Robert C. Adams		22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502		

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State  
Registrar

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
<p>a. Due to (or as a consequence of): Cardiac Arrhythmia</p> <p>b. Due to (or as a consequence of): Cardiomyopathy</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>		1 hour			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		3 years			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____			
		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier George Hennawi, MD			
		29c. License number D0059479		29d. Date signed (Month, Day, Year) September 18 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Hennawi, MD 925 Bishop Walsh Rd, Cumberland, MD 21502					
31. Date filed (Month, Day, Year) SEP 18 2006		32. Registrar's Signature John S. Jones			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006

30808

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roberto Aparicio</b>							2. Date of Death Month Day Year <b>September 12 2006</b>	3. Time of Death 12:00 AM
	4a. Facility Name (If not institution, give street and number) <b>Montgomery Village Health Care</b>			4b. City, Town, or Location of Death <b>Montgomery Village</b>			4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>216-13-1036</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>65 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>May 28, 1941</b>	9. Birthplace (State or Foreign Country) <b>El Salvador</b>
Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Montgomery Village</b>						10d. Inside City Limits <b>1 Yes 2 No</b>
	10e. Street and Number <b>6 Welbeck Court</b>			10f. Zip Code <b>20886</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify: Salvadorian</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Worker</b>			16b. Kind of Business/Industry <b>Construction</b>		
	17. Father's Name (First, Middle, Last) <b>Natividad Aparicio</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Emelia Quintanilla</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Maria M. Fernandez / Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15260 Wedgewood Drive, Greencastle, PA 17225</b>					
Physician /Medical Examiner	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>			Date <b>September 15, 2006</b>	20c. Location - City or Town, State <b>Alexandria, Virginia</b>	
Medical Certification; To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Tracy A Stuver</b>			22. Name and Address of Facility <b>DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death					
	<p>a. <b>Congestive Heart Failure</b> Due to (or as a consequence of):</p> <p>b. <b>Cardiomyopathy</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
	23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>			23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>			23d. Date of delivery Month Day Year		
	23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>								
	24a. Was an autopsy performed? <b>1 Yes 2 No</b>			24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>					
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>			26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
	27. Manner of Death <b>1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined</b>			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>								
	29b. Signature and title of certifier <b>→</b>			29c. License number <b>H0051280</b>			29d. Date signed (Month, Day, Year) <b>9-12-06</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anushiravan Dadgar M.D., 9715 Medical Center Drive, #201, Rockville, MD 20850</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>			32. Registrar's Signature <b>→ [Signature]</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30809

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Andy Arhar, Jr.</b>							2. Date of Death Month Day Year <b>September 11, 2006 3:30a M</b>	3. Time of Death		
	4a. Facility Name (If not institution, give street and number) <b>Arcola Health &amp; Rehab. Center</b>			4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>				
Funeral Director	5. Social Security Number <b>220-05-2411</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug. 25, 1915</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>			
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Adelphi</b>								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>2262 Lewisdale Drive</b>			10f. Zip Code <b>20783</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1938-53</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>White</b> Specify:		
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cutter</b>			16b. Kind of Business/Industry <b>Printing</b>				
	17. Father's Name (First, Middle, Last) <b>Andy Arhar</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Mivec</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ernest J. Arhar/ Brother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11303 Kinder Lane, Dunkirk, Maryland 20754</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Gate of Heaven Cemetery</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>			Date <b>Sept. 14, 2006</b>	20c. Location - City or Town, State <b>Silver Spring, Maryland</b>			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death		
<p>a. <b>Myocardial Infarction</b> Due to (or as a consequence of): <b>Coronary Artery Disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus- Type II</b>									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier 	29c. License number <b>D52261</b>	29d. Date signed (Month, Day, Year) <b>September 11, 2006</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alan R. Segal, M.D. 1517 Hugo Circle, Silver Spring, MD 20901</b>			31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

4+1

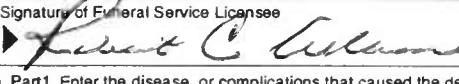
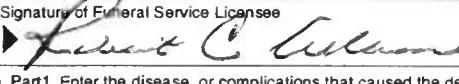
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30810  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stewart Edward Burcaw</b>					2. Date of Death Month <b>09</b> Day <b>12</b> Year <b>2006</b>	3. Time of Death <b>0450 M</b>			
	4a. Facility Name (If not institution, give street and number) <b>WMHS Braddock Campus</b>		4b. City, Town, or Location of Death <b>Cumberland</b>			4c. County of Death <b>Allegany</b>				
Funeral Director	5. Social Security Number <b>215-26-7664</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76 Yrs.</b>	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>04/07/1930</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>			
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Allegany</b> 10c. City, Town or Location <b>Cumberland</b>					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number <b>1413 Bedford Street</b>			10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1959-</b> If Yes, Give Year or Dates: <b>1962</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Specify:</b>		14. Race - American Indian, Black, White, etc. <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>			16b. Kind of Business/Industry <b>Manufacturing</b>			
	17. Father's Name (First, Middle, Last) <b>Charles Edward Burcaw</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Alleene Hilda Brown</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Kathleen M. Burcaw / wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1413 Bedford Street, Cumberland, MD 21502</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>			Date <b>09/15/2006</b> 20c. Location - City or Town, State <b>Cumberland, MD</b>			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Adams Family Funeral Home, P.A.</b>						
				<b>404 Decatur Street, Cumberland, MD 21502</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Congestive Heart Failure</b>							Approximate Interval Between Onset and Death <b>2 weeks</b>		
	a. Due to (or as a consequence of): <b>Congestive Heart Failure</b>									
	b. Due to (or as a consequence of): <b>Coronary Artery Disease</b>							5 years		
	c. Due to (or as a consequence of):									
	d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Kidney Disease</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D23774</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 12, 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL T. LIVENGOOD MD, 912 SETON DRIVE, CUMBERLAND MARYLAND 21502</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at all times.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5/10A  
NHS

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30811

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  Howard Harold Brinkman						2. Date of Death Month 09 Day 09 Year 06 7:10 A.M.	3. Time of Death
	4a. Facility Name (If not institution, give street and number)  WMHS - Braddock Campus			4b. City, Town, or Location of Death  Cumberland			4c. County of Death  Allegany	
Funeral Director	5. Social Security Number 214-07-5209	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 07/03/1918	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent  10a. State MD 10b. County Allegany 10c. City, Town or Location Cumberland						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1514 Oldtowne Manor, Apt. 1A			10f. Zip Code 21502			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Brakeman		16b. Kind of Business/Industry Railroad			
	17. Father's Name (First, Middle, Last) Howard C. Brinkman			18. Mother's Name (First, Middle, Maiden Surname) Emma Gracie				
	19a. Informant's Name/Relationship (Type, Print) David A. Brinkman / son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 261 Michael Street, Elizabethtown, PA 17022				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Mem. Park		Date 09/12/2006	20c. Location - City or Town, State Cumberland, MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)   Sepsis							Approximate Interval Between Onset and Death 2 weeks
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   Coronary artery disease							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year) Sept 9, 2006
	29b. Signature and title of certifier 							29c. License number DC033280
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SUNIL GUPTA 625 Kent Avenue, Cumberland, MD 21502							
	31. Date filed (Month, Day, Year) SEP 11 2006			32. Registrar's Signature 				

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-in-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

006 30812

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Ruth Estella Bender

2. Date of Death  
Month Day Year  
September 13, 2006 1827 P M

Physician  
/Medical  
Examiner

4a. Facility Name (If not institution, give street and number)

WMHS-Braddock Campus

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 10/31/1920	9. Birthplace (State or Foreign Country) Maryland
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Usual Residence of Decedent

10a. State MD	10b. County Allegany	10c. City, Town or Location Oldtown	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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10e. Street and Number 17322 Oldtown Road, SE	10f. Zip Code 21555	10g. Citizen of What Country? USA
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11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary	16b. Kind of Business/Industry Hospital
--	---	--

17. Father's Name (First, Middle, Last) Lawson Nixon	18. Mother's Name (First, Middle, Maiden Surname) Maude Estella Henry
---	--

19a. Informant's Name/Relationship (Type, Print) Kevin S. Bender / grandson	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16701 Pleasant Walk, Oldtown, Maryland 21555
--	---

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Davis Mem. Cem.	Date 09/17/2006	20c. Location - City or Town, State Cumberland, MD
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death ► 3 days
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23b. Part 2. Enter underlying causes, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): Pneumonia
--	--

	b. Due to (or as a consequence of):
--	-------------------------------------

	c. Due to (or as a consequence of):
--	-------------------------------------

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
--	--

24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
---	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
--	--	--------------------------	--	-----------------------------------

29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
---	--	--

29b. Signature and title of certifier 	29c. License number D0054004	29d. Date signed (Month, Day, Year) September 13, 2006
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shiv C. Khanna, M.D., 1221 E. National Highway, LaVale, Maryland 21502
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31. Date filed (Month, Day, Year) SEP 14 2006	32. Registrar's Signature 
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

► To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30813  
Certificate of Death

Reg. No.

1-  
For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SHIRLEY BLAKE</b>							2. Date of Death Month Day Year <b>September 5 2006</b>	3. Time of Death <b>7:25 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Baltimore Washington Medical Center</b>			4b. City, Town, or Location of Death <b>Glen Burnie</b>			4c. County of Death <b>Anne Arundel</b>				
Funeral Director	5. Social Security Number <b>216-36-6036</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>May 10 1939</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Annapolis</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number <b>29 W. Washington St. Apt 508</b>			10f. Zip Code <b>21401</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>10th</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Dietary</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Hospital</b>			16b. Kind of Business/Industry <b>Hospital</b>				
	17. Father's Name (First, Middle, Last) <b>Daniel Griffin</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Hytch</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Ronald Colbert (Son)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9605 Allerton Terrace Clinton, Md. 20735</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Larry G. Reese 100-483</b>			20b. Place of Disposition (Name of Cemetery or other place) <b>Bethesda Memorial Park</b>			Date <b>9-12-06</b>	20c. Location - City or Town, State <b>Annapolis, Md.</b>			
	21. Signature of Funeral Service Licensee <b>Larry G. Reese 100-483</b>			22. Name and Address of Facility <b>Wm. Reese &amp; Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>PNEUMONIA</b> Due to (or as a consequence of):  <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>2 WEEKS</b>  <b>3 WEEKS</b>		
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) <b>SEPTEMBER 5, 2006</b>		
	29b. Signature and title of certifier <b>Guillermo J. Giangreco, MD</b>								29c. License number <b>DOO62714</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GUILLERMO JOSE GIANGRECO 301 HOSPITAL DRIVE, MD 21061</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>			32. Registrar's Signature <b>John B. Blake</b>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30814

1 - For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death																					
<i>Lloyd, Eugene, Biggs</i>		09 10 2006				0015 M																					
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death																					
<i>Eastern Correctional Institution</i>		<i>Westover, MD</i>				<i>Somerset</i>																					
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>48</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <i>8 28 1958</i>	9. Birthplace (State or Foreign Country) <i>MD</i>																				
10a. State <i>Md.</i>		10b. County <i>Frederick</i>	10c. City, Town or Location <i>Frederick</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																				
10e. Street and Number <i>201 MADISON ST. Apt 6</i>			10f. Zip Code <i>21701</i>			10g. Citizen of What Country? <i>U.S.A.</i>																					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>UNK</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>																					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>UNK</i>			16b. Kind of Business/Industry <i>UNK</i>																					
17. Father's Name (First, Middle, Last) <i>AUSTIN JEFFERSON BIGGS</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Rosemary Barnes</i>																								
19a. Informant's Name/Relationship (Type, Print) <i>Rosemary JACKSON (mth)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>201 Madison St Apt 6 Frederick Md 21701</i>																								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Smithsburg Crematory Sept 12, 2006</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Smithsburg Crematory Sept 12, 2006</i>			20c. Location - City or Town, State <i>Md.</i>																					
21. Signature of Funeral Service Licensee <i>Gary J. Rollins</i>			22. Name and Address of Facility <i>GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST FREDERICK MD 21701</i>																								
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																											
Immediate Cause (Final disease or condition resulting in death) <i>CARDIOVASCULAR COLLAPSE</i>																											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																											
<table border="1"> <tr> <td>a.</td> <td colspan="3">Due to (or as a consequence of): <i>RESPIRATORY FAILURE</i></td> <td>Approximate Interval Between Onset and Death <i>min</i></td> </tr> <tr> <td>b.</td> <td colspan="3">Due to (or as a consequence of): <i>HIV</i></td> <td><i>yr</i></td> </tr> <tr> <td>c.</td> <td colspan="3">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td colspan="3"></td> <td></td> </tr> </table>								a.	Due to (or as a consequence of): <i>RESPIRATORY FAILURE</i>			Approximate Interval Between Onset and Death <i>min</i>	b.	Due to (or as a consequence of): <i>HIV</i>			<i>yr</i>	c.	Due to (or as a consequence of):				d.				
a.	Due to (or as a consequence of): <i>RESPIRATORY FAILURE</i>			Approximate Interval Between Onset and Death <i>min</i>																							
b.	Due to (or as a consequence of): <i>HIV</i>			<i>yr</i>																							
c.	Due to (or as a consequence of):																										
d.																											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																											
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred																					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																							
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																											
29b. Signature and title of certifier <i>GURSEWA S. PABLA M.D.</i>		29c. License number <i>D0009850</i>			29d. Date signed (Month, Day, Year) <i>Sep 10, 2006</i>																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>GURSEWA S. PABLA M.D.</i>																											
31. Date filed (Month, Day, Year) <i>SEP 15 2006</i>		32. Registrar's Signature <i>[Signature]</i>																									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30815

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death		
<b>SAMUEL W BLALOCK</b>		September 12 2006		10:00 AM		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death		
<b>Christa Medical Center</b>		<b>La Plata</b>		<b>Charles</b>		
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT 1, 1923</b>	
10a. State <b>SC</b>		10b. County <b>GREENVILLE</b>		10c. City, Town or Location <b>GREENVILLE</b>		
10e. Street and Number <b>8 TULANE AVENUE</b>		10f. Zip Code <b>29617</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW-2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SUPERVISOR</b>		16b. Kind of Business/Industry <b>U.S. GOVERNMENT</b>		
17. Father's Name (First, Middle, Last) <b>WILLIAM JASON BLALOCK</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ELVIRA MARTHA WILLIAMS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>NANCY D. LAWSON - DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9210 CRESCENT LANE, LA PLATA, MARYLAND 20646</b>		20c. Location - City or Town, State <b>SEPTEMBER 15, 2006 VIRGINIA BEACH, VA</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Park N. Bishum</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN MEM. GDNS.</b>		22. Name and Address of Facility <b>P.O. BOX 156, WALDORF, MD 20604</b>		
21. Signature of Funeral Service Licensee <b>M00053</b>		22. Name and Address of Facility <b>HUNTT FUNERAL HOME 3035 OLD WASHINGTON RD.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death				
a. Due to (or as a consequence of): <b>Acute Myocardial Infarction</b>						
b. Due to (or as a consequence of): <b>Ventricular fibrillation</b>						
c. Due to (or as a consequence of):						
d. Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29d. Date signed (Month, Day, Year) <b>9/12/2006</b>				
29b. Signature and title of certifier <b>► Nalin Mathur MD</b>		29c. License number <b>52289</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nalin Mathur 1051 Patricks Drive Suite 404 Waldorf, MD 20603</b>						
31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>		32. Registrar's Signature <b>Renee B. Smith</b>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30816

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death Hour:Minute AM/PM
	James S.		Barber Sr.		9-10-06	11:58P M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death
	6105 Bivins Place			LaPlata		Charles
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) October 17, 1939	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent		10c. City, Town or Location			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Maryland Charles	LaPlata					
10e. Street and Number 6105 Bivins Place			10f. Zip Code 20646		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Masonary		16b. Kind of Business/Industry Clarke Construction		
17. Father's Name (First, Middle, Last) John B. Barber			18. Mother's Name (First, Middle, Maiden Surname) Laura Lyles			
19a. Informant's Name/Relationship (Type, Print) Mary Barber / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6105 Bivins Place, LaPlata MD 20646			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Ch.CEM 9/16/06 LaPlata, Maryland		20c. Location - City or Town, State Adams Funeral Home PA Aquasco MD 20608	
21. Signature of Funeral Service Licensee Lloyd			22. Name and Address of Facility 191 Adams Funeral Home PA Aquasco MD 20608			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
<p>a. Due to (or as a consequence of): Metastatic Small Ce Ca of Lung</p> <p>b. Due to (or as a consequence of): Insulin dependent DM</p> <p>c. Due to (or as a consequence of): HTN</p> <p>d.</p>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier ► Jyoti		MD		29c. License number DO057999		29d. Date signed (Month, Day, Year) 9/11/06
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANISHA JARIWALA, MD 11631 Terrace Drive Ste 103, Waldorf, MD 20603						
31. Date filed (Month, Day, Year) SEP 14 2006		32. Registrar's Signature Jyoti				

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

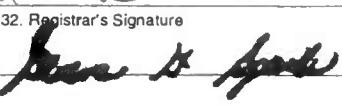
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30817  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Bowmann</b>							2. Date of Death Month Day Year <b>September 13, 2006</b>			3. Time of Death a <b>00:55 M</b>	
	4a. Facility Name (If not institution, give street and number) <b>1606 Boston Road</b>			4b. City, Town, or Location of Death <b>Pocomoke City</b>			4c. County of Death <b>Worcester</b>					
Funeral Director	5. Social Security Number <b>220-16-9744</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>81 Yrs.</b>	If Under 1 Year Months <b>8/13/1925</b>	If Under 24 Hrs. Days <b>8/13/1925</b>	8. Date of Birth (Month Day Year) <b>8/13/1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
	10a. State <b>Maryland</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Pocomoke City</b>			10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>				
To Be Completed by Funeral Director	10e. Street and Number <b>1606 Boston Road</b>			10f. Zip Code <b>21851</b>			10g. Citizen of What County? <b>USA</b>					
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white</b>			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) - Supervisor</b>			16b. Kind of Business/Industry <b>Maintenance</b>					
	17. Father's Name (First, Middle, Last) <b>Lawrence Fredric Baumann</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Hilda Cartwright</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Ruby B. Bowmann/wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1606 Boston Rd., Pocomoke City, MD 21851</b>								
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Union Greenbackville Cemetery</b>			Date <b>9/15/06</b>	20c. Location - City or Town, State <b>Greenbackville, VA</b>				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 103 Linden Ave., Pocomoke City, MD 21851</b>								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Lung Cancer</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>{ Lung Cancer</b>  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>COPD</b>										23e. Did tobacco use contribute to the cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>	
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		
	27. Manner of Death <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>		28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>			29c. License number <b>40056197</b>			29d. Date signed (Month, Day, Year) <b>9/17/2006</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert A. Carter 218 North St Sixisbury as 218</b>											
	31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>		32. Registrar's Signature 									

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2006 30818

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANGELA CROSS</b>								2. Date of Death Month Day Year <b>September 11 2006 0735AM</b>	3. Time of Death
	4a. Facility Name (If not institution, give street and number) <b>SUNRISE ASSISTED LIVING</b>				4b. City, Town, or Location of Death <b>SEVERNA PARK</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>218-18-5846</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Nov. 20, 1923</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Severna Park</b>								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>742 Ticonderoga Avenue</b>				10f. Zip Code <b>21146</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>1</b> <b>Medical Secretary</b>		16b. Kind of Business/Industry <b>Health</b>					
	17. Father's Name (First, Middle, Last) <b>Clement Siwinski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alexandra Popiolek</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Patricia Rutmiller/Guardian</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>200 Kirkley Road, Annapolis, MD 21401</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>MD Veterans Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>			Date <b>Sep. 15, 2006</b>	20c. Location - City or Town, State <b>Crownsville, MD</b>			
	21. Signature of Funeral Service Licensee <b>James E. Barranco</b>		22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>PNEUMONIA</b>				Approximate Interval Between Onset and Death <b>6 DAYS</b>					
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DYSPHAGIA</b>				Approximate Interval Between Onset and Death <b>6 MONTHS</b>					
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>9 Unknown</b>				23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b> <b>OSTEOARTHRITIS</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
					23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ASSISTED LIVING</b>							
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Michael A. Avkaro MD</b>							
			29c. License number <b>D46360</b>							
			29d. Date signed (Month, Day, Year) <b>September 11, 2006</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL A. AVKARO 8601 Veterans Highway Millersville MD</b>									
Medical Certification: To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature <b>Michael A. Avkaro</b>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 26a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30819

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

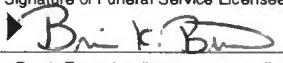
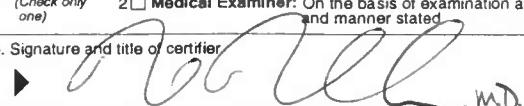
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached (or use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death
Dellas Lorraine Cusick		September 7 2006				9:50 p <sup>M</sup>
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death
5320 Skipjack Drive		Cambridge				Dorchester
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct. 18, 1925	9. Birthplace (State or Foreign Country) Minnesota
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State MD	10b. County Dorchester	10c. City, Town or Location Cambridge				
10e. Street and Number 5320 Skipjack Drive			10f. Zip Code 21613			10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry own home
17. Father's Name (First, Middle, Last) Edgar Spleiss			18. Mother's Name (First, Middle, Maiden Surname) Bessie Volkenant			
19a. Informant's Name/Relationship (Type, Print) Craig Cusick son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5320 Skipjack Dr. Cambridge, MD 21613			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.			Date 9/12/06
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust St. Cambridge, MD 21613			20c. Location - City or Town, State Hurlock, MD
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
<p>a. <u>Sepsis</u> Due to (or as a consequence of):</p> <p>b. <u>Social decubitus ulcer</u> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's dementia, atherosclerotic and vascular disease</u>						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number DS0804				
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 9-8-06				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Melkus, MD 408 Byn Street Cambridge, MD 21613						
31. Date filed (Month, Day, Year) SEP 08 2006		32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND #23a, Pt II PER PHYS DB Certificate of Death

Reg. No. 2006 30820  
9/7/4706 CCHD

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year				3. Time of Death			
	Virginia Davis Christie				September 9, 2006				1:30 P M			
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death				
	Manor Care			Bethesda				Montgomery				
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) April 4, 1925	9. Birthplace (State or Foreign Country) North Carolina					
10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spring											10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8902 1st Avenue				10f. Zip Code 20910				10g. Citizen of What Country? US				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant				16b. Kind of Business/Industry US Census Bureau				
17. Father's Name (First, Middle, Last) Robert H. Davis, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Myrtle Warren							
19a. Informant's Name/Relationship (Type, Print) Bill Christie - Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8902 1st Avenue, Silver Spring, MD 20910							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans' Cem 9-13-06				Date	20c. Location - City or Town, State Cheltenham, MD			
21. Signature of Funeral Service Licensee ► John Hyde M01391				22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd.				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS MONTHS				
Immediate Cause (Final disease or condition resulting in death)				a. <i>Multiorgan failure</i> . ARRYTHMIA								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				b. ANEMIA				MONTHS				
				c. MULTIORGAN FAILURE				MONTHS				
				d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year N/A				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
<i>Anemia</i>											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											26. Place of Death (Check only one)	
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	
28a. Date of Injury (Month, Day Year)						28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											29c. License number D19609.	29d. Date signed (Month, Day, Year) 9-11-06
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 DARNESTOWN ROAD SUITE 202 GAITHERSBURG MD 20878											32. Registrar's Signature KAREN R. TULI	
31. Date filed (Month, Day, Year) SEP 14 2006				32. Registrar's Signature KAREN R. TULI								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified all once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30821

1- For State Registrar AMEND#19aperFH9/14/06, BMW, MoCo

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death			
	<i>XIN DAVID HANG CHEN</i>						9/9/06	4:43 PM			
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death				
	<i>PRINCE GEORGE'S HOSPITAL CENTER</i>			<i>CHEVERLY</i>			<i>PRINCE GEORGE'S</i>				
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 3-17-1935	9. Birthplace (State or Foreign Country) China				
	Usual Residence of Decedent										
	10a. State <i>MD</i>	10b. County <i>PRINCE GEORGE'S</i>	10c. City, Town or Location <i>HYATTSVILLE</i>					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <i>4310 JEFFERSON STREET</i>			10f. Zip Code <i>20781</i>			10g. Citizen of What Country? <i>United States</i>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>ASIAN</i>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teacher</i>			16b. Kind of Business/Industry <i>Educational</i>				
	17. Father's Name (First, Middle, Last) <i>UNAVAILABLE</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>UNAVAILABLE</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Baowen Jin</i> <i>Jin, Baowen/Spouse</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4310 Jefferson St. #104 Hyattsville, MD 20781</i>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Chesapeake Crematory, Inc.</i>			Date <i>09/14/2006</i>	20c. Location - City or Town, State <i>Beltsville, Maryland</i>			
	21. Signature of Funeral Service Licensee <i>J. M. TSION</i>					22. Name and Address of Facility <i>Thibadeau Mortuary Service, P.A.</i> <i>933 Gist Ave., LL, Silver Spring, MD 20910</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>PULMONARY EDEMA</i>								Approximate Interval Between Onset and Death		
	b. Due to (or as a consequence of): <i>- ACUTE MYOCARDIAL ATTACK</i>										
	c. Due to (or as a consequence of): <i>MORTALIC ACIDOSIS</i>										
	d.										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury : At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>D0055703</i>						29d. Date signed (Month, Day, Year) <i>9/9/06</i>		
	29b. Signature and title of certifier <i>Berhan</i>										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DR TSION BERHANE</i>		30b. Hospital Drive <i>3001 HOSPITAL DRIVE</i>						30c. Location (Street and Number or Rural Route Number, City or Town, State) <i>CHEVERLY, MD 20785</i>		
State Registrar	31. Date filed (Month, Day, Year) <i>SEP 14 2006</i>		32. Registrar's Signature <i>James B. Aponte</i>								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30822

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

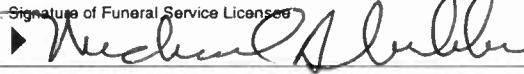
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Ching Ho Chu		September 10, 2006				1:10 P.M.	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Shady Grove Adventist Nursing Center		Rockville				Montgomery	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
202-60-5565		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	91 Yrs.			June 27, 1915	China
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Maryland	Montgomery	Gaithersburg					
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
1 Marsh Lane			20878			United States	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry		
Elementary/Secondary (0-12)		College (1-4 or 5+) 4			Engineer Chinese Government		
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)			
Le-Kun Chu				Hu Yang			
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Rosa Jenny Wang/Daughter				4705 Longhorn Drive, Beltsville, Maryland 20705			
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Metropolitan Crematory		Sept. 13, 2006	Alexandria, Virginia		
21. Signature of Funeral Service Licensed							
							
22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of):							
b. Advanced Age Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number MD 58597		29d. Date signed (Month, Day, Year) September 11, 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
Shahryar Davari, M.D., 15225 Shady Grove Road, # 208, Rockville, Maryland 20850							
31. Date filed (Month, Day, Year) SEP 14 2006		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30823

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Martha Boatwright Corr</b>							2. Date of Death Month Day Year <b>September 11 2006</b>	3. Time of Death 8:00 P M
	4a. Facility Name (If not institution, give street and number) <b>Sunrise of Montgomery Village</b>			4b. City, Town, or Location of Death <b>Gaithersburg</b>			4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>241-42-3167</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Nov. 4, 1925</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Montgomery Village</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>19310 Club House Road</b>			10f. Zip Code <b>20886</b>			10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>4</b> <b>Store Manager</b>			16b. Kind of Business/Industry <b>Retail Sales</b>		
	17. Father's Name (First, Middle, Last) <b>Edgar Vaughn Boatwright</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dillard Smith</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>William E. Corr IV / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25101 Chambliss Court , Gaithersburg, MD 20882</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>TRACY A. Steven</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Hill Cemetery</b>		Date <b>September 15, 2006</b>	20c. Location - City or Town, State <b>Danville, Virginia</b>		
	21. Signature of Funeral Service Licensee <b>Tracy A. Steven</b>								
	22. Name and Address of Facility <b>DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877</b>								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Alzheimer's Dementia</b> Approximate Interval Between Onset and Death <b>Yrs.</b>								
	23b. Part II. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Myocarditis</b> Due to (or as a consequence of): <b>Alzheimer's Dementia</b> Due to (or as a consequence of): <b>Myocarditis</b> Due to (or as a consequence of): <b>Alzheimer's Dementia</b> Due to (or as a consequence of): <b>Myocarditis</b>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>Unknown</b>			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Living Assisted</b>								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred <b>In assisted living</b>								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <b>Abulfarag, MD</b>								
	29c. License number <b>D31391</b>								
	29d. Date signed (Month, Day, Year) <b>September 12 2006</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Suhair Abulfarag, M.D., 15215 Shady Grove Road, Suite 100, Gaithersburg, MD 20879</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>		32. Registrar's Signature <b>Suhair A. Abulfarag</b>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30824

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year <b>September 22, 2006</b>				3. Time of Death <b>1935 PM</b>	
<b>Erma Aline Dunford</b>		4b. City, Town, or Location of Death <b>Havre de Grace</b>				4c. County of Death <b>Harford</b>	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death <b>Havre de Grace</b>				4c. County of Death <b>Harford</b>	
Harford Memorial Hospital							
5. Social Security Number <b>220-42-8001</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>03/08/1948</b>	9. Birthplace (State or Foreign Country) <b>W. Virginia</b>
Usual Residence of Decedent		10a. State <b>MD</b> 10b. County <b>Harford</b> 10c. City, Town or Location <b>Aberdeen</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>453 Bernice Terrace</b>		10f. Zip Code <b>21001</b>				10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 0 Food Service</b>		16b. Kind of Business/Industry <b>Waitress</b>			
17. Father's Name (First, Middle, Last) <b>James Franklin Lewis</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Kansas Lorretha Workman</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Avery Mabe (son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>453 Bernice Terrace, Aberdeen, MD 21001</b>				20c. Location - City or Town, State <b>W. Chester, PA</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris &amp; Co. Inc.</b>		Date <b>09/25/2006</b>		20c. Location - City or Town, State <b>Tanning-Cargo Funeral Home, P.A.</b>	
21. Signature of Funeral Service Licensee <b>Phyllis C. Bellman</b>		22. Name and Address of Facility <b>333 S. Parke St., Aberdeen, Maryland 21001</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <b>GI bleed</b>				Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): <b>Cirrhosis</b>					
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23g. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				23h. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D0062903</b>				29d. Date signed (Month, Day, Year) <b>09/23/06</b>	
29b. Signature and title of certifier 							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANAS ATRASH MD 319 S Union Ave Havre De Grace, MD</b>							
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature 				33. Date signed (Month, Day, Year) <b>21078</b>	

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30825  
Reg. No.1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

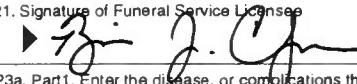
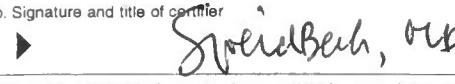
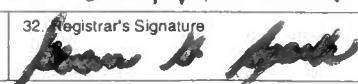
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important! If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Cecile G. Duval</b>				2. Date of Death Month Day Year <b>September 9 2006</b>	3. Time of Death M <b>6:55 p.m.</b>
4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>	
4c. County of Death <b>Anne Arundel</b>					
5. Social Security Number <b>461-16-7906</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 13 1919</b>
9. Birthplace (State or Foreign Country) <b>Texas</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>XX</b>			
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Edgewater</b>	
10e. Street and Number <b>162 Southdown Road</b>				10f. Zip Code <b>21037</b>	
10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Ossie Graves Gilbert</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mae Caswell</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Stewart E. Duval (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>162 Southdown Road, Edgewater, MD 21037</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Christ Church Cem.</b>		Date <b>9-14-2006</b>	20c. Location - City or Town, State <b>West River, MD</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>Days</b>	
<p>a. Due to (or as a consequence of): <b>Coagulopathy</b></p> <p>b. Due to (or as a consequence of): <b>Myeloproliferative disorder</b></p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>				<b>Weeks</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D46052</b>			
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>9/11/06</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sjoerd Bech, MD 2001 Medical Parkway Annapolis, MD</b>					
31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30826

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

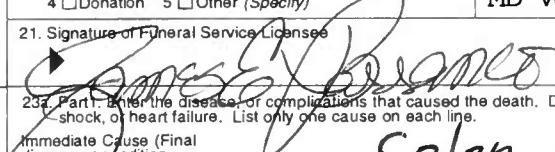
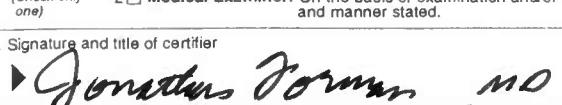
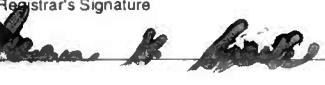
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year <b>Sep. 8, 2006</b>		3. Time of Death M
<b>Ethna Ada Duckett</b>				
4a. Facility Name (If not institution, give street and number) <b>795 Stinchcomb Avenue</b>		4b. City, Town, or Location of Death <b>Severna Park</b>		4c. County of Death <b>Anne Arundel</b>
5. Social Security Number <b>215-16-2088</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <b>Oct. 3, 1921</b>
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>MD</b>		
10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Severna Park</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>795 Stinchcomb Avenue</b>		10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Production Binder</b>		16b. Kind of Business/Industry <b>Pavner Press</b>
17. Father's Name (First, Middle, Last) <b>Jacob Lulay</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ethna P. O'Byrne</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Pamela L. Combs/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>795 Stinchcomb Avenue, Severna Park, MD 21146</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>MD Veterans Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>		Date <b>Sep. 12, 2006</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>Years</b>		
a. _____ Due to (or as a consequence of): <b>Colon Cancer</b>				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9/12/2006</b>		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Cannot be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier 		29c. License number <b>D 0023811</b>		29d. Date signed (Month, Day, Year) <b>9/12/2006</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jonathan Forman, MD 1406B Scrain #304 Glen Burnie MD 21061</b>		31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		
32. Registrar's Signature 		ORIGINAL		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2006 30827

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
		Mary Margaret Ellwanger		Sept. 14, 2006		12:40 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
Ruxton Health		Denton		Ca.			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-03-3564		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	91 Yrs.			July 3, 1915	Md.
Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location	
		Md.		Caroline		Greensboro	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?			
11831 Knife Box Rd.		21639		U.S.A.			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced							
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 12		College (1-4 or 5+) 4		Dairy and Grain Farmer		Agriculture	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)					
William Richard Gardner		Mary Agatha Kibler					
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		Date		20c. Location - City or Town, State	
Charles L. Ellwanger son		11640 Knifebox Rd. Greensboro Md. 21639		9-19-06		Greensboro Md.	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		22. Name and Address of Facility		P.o. box 160 Greensboro Md.	
		Greensboro Cem.					
21. Signature of Funeral Service Licensee <i>Stephen C Fleegle</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		22. Name and Address of Facility <i>Fleegle-Helfenbein</i>				Approximate Interval Between Onset and Death <i>10 days</i> <i>1 year</i>	
a. Due to (or as a consequence of): <i>Cerebrovascular accident</i>							
b. Due to (or as a consequence of): <i>Atrial fibrillation</i>							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Gastrointestinal bleeding</i>							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Lee Hanell ms</i>		29c. License number <i>D35284</i>		29d. Date signed (Month, Day, Year) <i>9/16/06</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ANDREA ALEXANDRA 219 S. Washington St Easton MD 21601</i>							
31. Date filed (Month, Day, Year) <i>SEP 18 2006</i>		32. Registrar's Signature <i>Lee Hanell</i>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend #10b FH/Phys 09-20-2006 CMM Certificate of Death  
1- For State Registrar Reg. No. 2006 30828

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Deborah Fleming</b>							2. Date of Death Month Day Year <b>Sept. 9, 2006</b>	3. Time of Death <b>7:11P M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Frederick</b>			4c. County of Death <b>Frederick</b>			
Funeral Director	5. Social Security Number <b>242-96-1708</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>53 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month Day, Year) <b>May 30, 1953</b>	9. Birthplace (State or Foreign Country) <b>Georgia</b>			
	10a. State <b>Maryland</b>			10b. County <b>Washington Frederick</b>	10c. City, Town or Location <b>Boonsboro</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>203 Tiger Way</b>			10f. Zip Code <b>21713</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <b>white</b> Specify:		
	15. Decedent's Education (Specify only highest grade completed)  <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  <b>Teacher</b>			16b. Kind of Business/Industry <b>Education</b>			
	17. Father's Name (First, Middle, Last) <b>James F. McLamb</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Netta Mattocks</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Bradley Fleming - Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 Tiger Way, Boonsboro, Maryland 21713</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Mt. Olivet Cemetery</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		Date <b>9-13-2006</b>	20c. Location - City or Town, State <b>Frederick, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Sharon Camille Cline</b>				22. Name and Address of Facility Stauffer Funeral Home <b>1621 Opossumtown Pike, Frederick, Maryland 21702</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>7 day</b>		
	<p>a. Due to (or as a consequence of): <b>Sepsis, Pneumonia</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>									
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year <b>- - -</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Diabetes mellitus</b> <b>Hypertension</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
								28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>65 C Thomas, Frederick, MD 21702</b>	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier <b>Shah Hirun, MD</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shah Hirun, MD</b>							29c. License number <b>D 51643</b>	29d. Date signed (Month, Day, Year) <b>9-12-06</b>	
	31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>							32. Registrar's Signature <b>Shah Hirun, MD</b>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

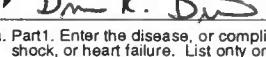
**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

**Req. No.**

2006 30829

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Robert Calieb Foxwell</b>						2. Date of Death Month Day Year <b>September 14 2006</b>	3. Time of Death <b>5:30 a.m.</b>	
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>106 Railroad Avenue</b>			4b. City, Town, or Location of Death <b>Hurlock</b>			4c. County of Death <b>Dorchester</b>		
To Be Completed by Funeral Director		5. Social Security Number <b>217-10-8340</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 29, 1916</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
		Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Hurlock</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number <b>106 Railroad Avenue</b>			10f. Zip Code <b>21643</b>			10g. Citizen of What Country? <b>USA</b>		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>diesel mechanic</b>			16b. Kind of Business/Industry <b>transportation</b>		
		17. Father's Name (First, Middle, Last) <b>Robert Levin Foxwell</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes May Davis</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Robert G. Foxwell</b> son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 Railroad Ave., Hurlock, MD 21643</b>						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dorchester Memorial Park 9/18/06</b>			Date	20c. Location - City or Town, State <b>Cambridge, MD</b>		
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Thomas Funeral Home P.A.</b>			23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) <b>Mesothelioma</b>			
		23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					Approximate Interval Between Death and Death <b>17 1/2 yrs</b>			
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29b. Signature and title of certifier 		29c. License number <b>DZ9887</b>			29d. Date signed (Month, Day, Year) <b>9/15/06</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David H. Smith M.D. 29466 Pintail Drive, Easton, MD 21601</b>								
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>		32. Registrar's Signature 						

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** Alter this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

any injury or other traumatic event, the Medical Examiner shall be notified at once.

**Baltimore, Maryland 21215-0036**

**Baltimore, Maryland 21215-0036 ✓ All**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, **ALL MEDICAL EXAMINERS MUST BE NOTIFIED IMMEDIATELY.**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30830  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Warren B. Gindhart, Jr.</b>							2. Date of Death Month Day Year <b>September 21, 2006 5:04 P M</b>	3. Time of Death
	4a. Facility Name (If not institution, give street and number) <b>9619 Oriole Lane</b>			4b. City, Town, or Location of Death <b>Bel Alton</b>			4c. County of Death <b>Charles</b>		
Funeral Director	5. Social Security Number <b>143-42-4211</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 9, 1950</b>	9. Birthplace (State or Foreign Country) <b>PA</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Charles</b> 10c. City, Town or Location <b>Bel Alton</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number <b>9619 Oriole Lane</b>			10f. Zip Code <b>20611</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Driver/Delivery</b>			16b. Kind of Business/Industry <b>Auto Parts</b>		
	17. Father's Name (First, Middle, Last) <b>Warren Blaine Gindhart, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Veronica Foyne</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Veronica Harless/Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9619 Oriole Lane, Bel Alton, MD 20611</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Brinsfield-Echols</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State <b>Charlotte Hall, MD</b>		
	21. Signature of Funeral Service Licensee <b>David C. Echols</b>			22. Mailing Address of Facility <b>AREHART-ECHOLS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata, MD 20646</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Liver Cancer</b>								Approximate Interval Between Onset and Death
	23b. Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. Due to (or as a consequence of): <b>Liver Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <b>Karen M. Mathur</b>								
	29c. License number <b>D28352</b>								
	29d. Date signed (Month, Day, Year) <b>9/22/06</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PO Box 1703 La Plata MD 20646</b>								
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature <b>Karen M. Mathur</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30831  
Reg. No.

1- For  
State  
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Mason Lee Grogg						2. Date of Death Month Day Year SEPTEMBER 5, 2006	3. Time of Death 7:55A M		
	4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>CUMBERLAND</b>			4c. County of Death <b>ALLEGANY</b>			
Funeral Director	5. Social Security Number <b>235-52-5157-A</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>12/11/1933</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent WV Mineral		10a. State 10b. County WV Mineral				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>20 City View Avenue, P.O. Box 22</b>			10f. Zip Code <b>26767</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Foreman</b>			16b. Kind of Business/Industry <b>Manufacturing</b>				
	17. Father's Name (First, Middle, Last) <b>Basil Lee Grogg</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lillie Louise Helmick</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Shelby J. Grogg / wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 22, Wiley Ford, West Virginia 26767</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Robert C. Adams</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>			Date <b>09/08/2006</b>	20c. Location - City or Town, State <b>Cumberland, MD</b>		
	21. Signature of Funeral Service Licensee <b>Robert C. Adams</b>			22. Name and Address of Facility Adams Family Funeral Home, P.A. <b>404 Decatur Street, Cumberland, MD 21502</b>						
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Adenocarcinoma of Lung</b>								Approximate Interval Between Onset and Death <b>2 months</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Adenocarcinoma of Lung</b>								Approximate Interval Between Onset and Death <b>2 months</b>	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic Cardiomyopathy</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>H. Chotani</b>						
				29c. License number <b>DS8853</b>						
				29d. Date signed (Month, Day, Year) <b>9/6/06</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HABIB CHOTANI, 131 PENNSYLVANIA AVE, CUMBERLAND, MD 21502</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 06 2006</b>			32. Registrar's Signature <b>John B. Jones</b>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4/1/04

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Baltimore, MD 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

DV  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed  
 within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and  
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No.

2006 30832

**1- For State Registrar**

<b>Physician/ Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Gerald Edward Garcia</b>					2. Date of Death Month Day Year <b>September 15, 2006</b>	3. Time of Death 1718 hrs	
<b>Funeral Director</b>	4a. Facility Name (if not institution, give street and number) <b>Route 23 North</b>			4b. City, Town, or Location of Death <b>Norrisville</b>			4c. County of Death <b>Harford</b>	
<b>To Be Completed by Funeral Director</b>	5. Social Security Number <b>218-90-6856</b>	6. Sex <b>1 XM 2 F</b>	7. Age (In yrs. last birthday) <b>42</b>	Yrs.	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (MM/DD/YYYY) <b>Feb. 26, 1964</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	10a. State <b>MD</b>			10b. County <b>Harford</b>			10c. City, Town or Location <b>Aberdeen</b>	
	10e. Street and Number <b>3919 W. Chapel Rd.</b>				10f. Zip Code <b>21001</b>			10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify <b>White</b>			14. Race - American Indian, Black, White, etc.
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Civil service</b>			16b. Kind of Business/Industry <b>U.S. Government</b>
	17. Father's Name (First, Middle, Last) <b>Edward L. Garcia</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Constance E. Nelson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Anne M. Hamm (Sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25 Open Meadow Ct. Elkton, MD 21921</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  <i>Jane C. Bellman</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Mem. Gdns.</b>		Date <b>9/20/06</b>	20c. Location - City or Town, State <b>Aberdeen, Maryland</b>		
	23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a <b>Multiple Injuries</b> Due to (or as a consequence of):  b: _____ Due to (or as a consequence of):  c: _____ Due to (or as a consequence of):  d: _____							
	<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other, Scene					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year) <b>Sep 15, 2006</b>		28b. Time of Injury 1710 hrs		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred <b>Driver auto auto collision</b>							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Local Street</b>							
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Route 23 North, Norrisville, MD</b>							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Margarita Korell</i>					
	29c. License number <b>O.C.M.E.</b>							
	29d. Date signed (Month, Day, Year) <b>September 16, 2006</b>							
	30. Name and address of person who completed cause of death (Item 23a) <b>Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>							
<b>State Registrar</b>	31. Date filed (Month, Day, Year) <b>SEP 15 2005</b>		32. Registrar's Signature <i>Margarita Korell</i>					

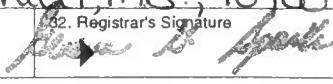
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

**Amend Item 26 per Maryland 0859, 09/28/06 Health and Mental Hygiene  
Certificate of Death**

Reg. No.

2006 30833

1- For  
State  
Registrar

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year				3. Time of Death									
	ROBERT LEON GOOSLIN							SEPTEMBER 11, 2006 9:15AM													
<b>Funeral Director</b>	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death													
	44625 LACI'S WAY			LEONARDTOWN				ST. MARY'S													
<b>To Be Completed by Funeral Director</b>	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)											
	404-32-2662			76 Yrs.					OCT. 7, 1929	KENTUCKY											
Usual Residence of Decedent																					
10a. State		10b. County		10c. City, Town or Location							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
MARYLAND		CHARLES		WALDORF							<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number				10f. Zip Code					10g. Citizen of What Country?												
2740 MARLETT PLACE				20601					U.S.A.												
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, Give Year or Dates: NAVY			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICIAN					16b. Kind of Business/Industry GOOSLIN ELECTRIC												
17. Father's Name (First, Middle, Last) LANDO GOOSLIN					18. Mother's Name (First, Middle, Maiden Surname) ANNE ALMA PERRY																
19a. Informant's Name/Relationship (Type, Print) ROBERT L. GOOSLIN-SON					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 932 UPPER PINDELL RD., LOTHIAN, MD 20711																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEMORIAL GDNS.				Date	20c. Location - City or Town, State WALDORF, MARYLAND												
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
Immediate Cause (Final disease or condition resulting in death)																					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																					
{ a. Due to (or as a consequence of):  Lung Cancer b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____																					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																					
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Daughters Residence				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number H0055751				29d. Date signed (Month, Day, Year) 9-13-06													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, MD, 40900 Merchant's Ln., #205, Leonardtown, MD																					
31. Date filed (Month, Day, Year) SEP 28 2006				32. Registrar's Signature 				33. Date filed (Month, Day, Year) 2006 30833													

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the medical examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State  
Registrar

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**

**Certificate of Death**

Reg. No.

2006 30834

**1- For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

Peter John Glamp

2. Date of Death

Month Day Year

3 Time of Death

1835 hrs

**Funeral  
Director**

4a. Facility Name (if not institution, give street and number)

1709 Leisure Way

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

5. Social Security Number

6. Sex

7. Age (In yrs. last birthday)

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

9. Birthplace (State or Foreign Country)

PA.

215-68-1199

1  M 2  F

49

Yrs.

Months

Days

Hours

Min.

Sept. 25, 1956

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

W. VA.

Morgan

Berkley Springs

1  Yes 2  No

10e. Street and Number

50 Silver Creek Lane

10f. Zip Code

25411

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No specify

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales representative

16b. Kind of Business/Industry

Jewelry Manufacturing

17. Father's Name (First, Middle, Last)

Walter Glamp

18. Mother's Name (First, Middle, Maiden Surname)

Eileen Martin

19a. Informant's Name/Relationship (Type, Print)

Kelly L. Glamp - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

50 Silver Creek Lane, Berkley Springs, West VA.

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State4  Donation 5  Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens Lakemont Memorial

Date

09-28-06

20c. Location - City or Town, State

Davidsonville, MD.

21. Signature of Funeral Service Licensee

*E. Brian Powell*

22. Name and Address of Facility

Beall Funeral Home  
6512 N.W. Crain Hwy., Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. **Oxycodone intoxication**

Due to (or as a consequence of):

b. **Cocaine use**

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED item#23a,27,28a-f,perME,g860, 10/11/06 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy4  Pregnant at time of death 5  Other (Specify)9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  NoHospital: 1  Inpatient 2  ER/Outpatient 3  DOAOther: 4  Nursing Home 5  Residence 6  Other Scene

27. Manner of Death

1  Natural2  Accident3  Suicide4  Homicide5  Pending Investigation6  Could not be determined

28a. Date of Injury (Month, Day, Year)

Fnd 9/23/2006

28b. Time of Injury

Fnd 6:30 pm

28c. Injury at Work?

1  Yes 2  No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) found in residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1709 Leisure Way

Crofton, MD

29a. Certifier (Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Melissa Brassell, M.D.*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 24, 2006

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

SEP 28 2006

32. Registrar's Signature

*Melissa K. Brassell*

ORIGINAL

Baltimore, MD 21215-0036

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any

injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial - transit

completely filed in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30835

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  Della I. Hillegass						2. Date of Death Month Day Year 09 16 06	3. Time of Death 1542 M	
	4a. Facility Name (If not institution, give street and number)  WMHS- Braddock Campus			4b. City, Town, or Location of Death  CUMBERLAND			4c. County of Death  ALLEGANY		
Funeral Director	5. Social Security Number 205-30-6070	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09/27/1922	9. Birthplace (State or Foreign Country) Pennsylvania		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State PA 10b. County Bedford 10c. City, Town or Location Manns Choice 10e. Street and Number 2278 Allegheny Road 10f. Zip Code 15550 10g. Citizen of What Country? USA						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) George Lowery Anna Strouse						18. Mother's Name (First, Middle, Maiden Surname)		
	19a. Informant's Name/Relationship (Type, Print) Janet I. Mowry / daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3418 Allegheny Road, Manns Choice, PA 15550		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dry Ridge Cemetery			Date 09/19/2006	20c. Location - City or Town, State Manns Choice, PA	
	21. Signature of Funeral Service Licensee Rahel C. Schaefer						22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	Approximate Interval Between Onset and Death
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
29b. Signature and title of certifier William Lamm MD		29c. License number D25406		29d. Date signed (Month, Day, Year) 09/17/06			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. William Lamm 900 Seton Drive Cumberland, MD 21502							
31. Date filed (Month, Day, Year) SEP 18 2006		32. Registrar's Signature John D. Johnson					

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2006 30836

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RICHARD T. HERBERT</b>				2. Date of Death Month <b>9</b> Day <b>8</b> Year <b>2006</b>	3. Time of Death <b>1025 M</b>		
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>225-10-4981</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Feb 23 1910</b>	9. Birthplace (State or Foreign Country) <b>W. Virginia</b>	
	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Churchton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>5565 Deale Churchton Rd.</b>			10f. Zip Code <b>20733</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>12th 4yrs</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clergy</b>		16b. Kind of Business/Industry <b>Methodist Church</b>			
	17. Father's Name (First, Middle, Last) <b>Charles W. Herbert Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Dennis</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Richard T. Herbert Jr. (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>614 Mt. Lubentia Ct. East Largo, Md. 20774</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Lincoln Memorial</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lincoln Memorial</b>		Date <b>9-15-06</b>	20c. Location - City or Town, State <b>Suitland, Md.</b>		
	21. Signature of Funeral Service Licensee <b>Larry H. Reese NO0483</b>		22. Name and Address of Facility <b>Wm. Reese &amp; Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CORONARY ARTERY DISEASE</b>						Approximate Interval Between Onset and Death <b>5 years</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Diabetes, Type 2 HYPERTENSION</b>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>005158</b>					
	29b. Signature and title of certifier <b>Harvey J. Steinfeld MD</b>		29d. Date signed (Month, Day, Year) <b>9/9/2006</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HARVEY J. STEINFELD</b>		31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>					
	32. Registrar's Signature <b>Harvey J. Steinfeld</b>							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be utilized. All data.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30837

Reg. No.

1- For  
State  
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Louise Hurley</b>						2. Date of Death Month Day Year <b>September 10 2006</b>	3. Time of Death 4:00 p <sup>m</sup>
	4a. Facility Name (If not institution, give street and number) <b>306 Willis Street</b>			4b. City, Town, or Location of Death <b>Cambridge</b>			4c. County of Death <b>Dorchester</b>	
Funeral Director	5. Social Security Number <b>220-28-4684</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88 Yrs.</b>	II Under 1 Year Months Days	II Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 16, 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Dorchester</b>			10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>306 Willis Street</b>			10f. Zip Code <b>21613</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>7</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify:
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>cashier</b>			16b. Kind of Business/Industry <b>grocery store</b>	
	17. Father's Name (First, Middle, Last) <b>Hamilton Manning</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Eva McCollister</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Kay Adshead daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 433, Secretary, MD 21664</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Birk B</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>East New Market Cemetery 9/14/06</b>			Date <b>East New Market, MD</b>	
	21. Signature of Funeral Service Licensee <b>Birk B</b>			22. Name and Address of Facility <b>Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613</b>			20c. Location - City or Town, State	
Physician / Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>urosepsis</b> Due to (or as a consequence of): <b>arrhythmia</b> Due to (or as a consequence of): <b>hypertension</b> Due to (or as a consequence of): <b>congestive heart failure</b> Approximate Interval Between Onset and Death <b>1 week</b> <b>20 years</b> <b>10 years</b>							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>congestive heart failure</b>							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>► Johnson M</b>			29c. License number <b>H 59973</b>			29d. Date signed (Month, Day, Year) <b>9/12/06</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P Johnson 100 Bramble St, Cambridge, MD 21613</b>							
State Registrar	31. Date filed (Month Year) <b>SEP 13 2006</b>	32. Registrar's Signature <b>Meave A. Jones</b>						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30838

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

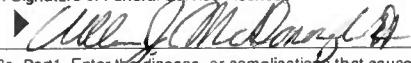
Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Kenneth Willard Harrington		September 7, 2006		6:30 AM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Baltimore VA Medical Center		Baltimore		N/A
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min.
218-18-8480				
10a. State Virginia		10b. County Loudoun		10c. City, Town or Location Lovettsville
10e. Street and Number 35 Park Place		10f. Zip Code 20180		10g. Citizen of What Country? U.S. of A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943 - 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator		16b. Kind of Business/Industry Decorating
17. Father's Name (First, Middle, Last) Howard George Harrington		18. Mother's Name (First, Middle, Maiden Surname) Helen Montgomery Baker		
19a. Informant's Name/Relationship (Type, Print) Gary Harrington - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Park Place, Lovettsville, VA 20180		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Sep 11 Alexandria, Virginia
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Loudoun Funeral Chapels 158 Catoctin Circle, SE, Leesburg, VA 20175		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> Pancreatic mass Due to (or as a consequence of): Prostate Cancer Due to (or as a consequence of): Renal failure Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 month 10 yrs 2 weeks				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Coronary artery disease, Hypertension</i>				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number P18817		
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) September 7, 2006		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Davino, MD 10 N. Green St. Baltimore, MD 21201				
31. Date filed (Month, Day, Year) SEP 15 2006				
32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30839  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Max Kleophas Haiden</b>							2. Date of Death Month Day Year <b>September 11, 06 11:45pM</b>	3. Time of Death	
	4a. Facility Name (If not institution, give street and number) <b>Charlotte Hall Veterans Home</b>			4b. City, Town, or Location of Death <b>Charlotte Hall</b>			4c. County of Death <b>St. Mary</b>			
Funeral Director	5. Social Security Number <b>215-22-9000</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Sept. 1, 1927</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Charles</b>	10c. City, Town or Location <b>Indian Head</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>1445 Ben Doane Road</b>			10f. Zip Code <b>20640</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Negative Engraver</b>			16b. Kind of Business/Industry <b>U.S. Government</b>				
	17. Father's Name (First, Middle, Last) <b>Kleophas Haiden</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Eder</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia C. Haiden Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1445 Ben Doane Rd., Indian Head, Md. 20640</b>					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>M00668</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>			Date <b>Sept. 15, 2006</b>	20c. Location - City or Town, State <b>Suitland, Maryland</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640</b>					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Approximate Interval Between Onset and Death					
	23c. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23d. Date of delivery Month Day Year					
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		
	28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Prince Frederick, Maryland 20678</b>					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D45092</b>			29d. Date signed (Month, Day, Year) <b>9/12/2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>110 Hospital Rd Suite 205, Prince Frederick, Maryland 20678</b>				32. Registrar's Signature 					
	31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>				33. Date signed (Month, Day, Year)					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

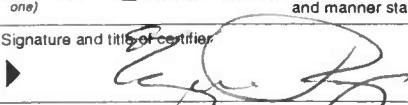
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30840

Reg. No.

1- For  
State  
Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MATTIE B. HILL</b>						2. Date of Death Month Day Year <b>SEPTEMBER 13, 2006</b>	3. Time of Death 11:15 A M		
	4a. Facility Name (If not institution, give street and number) <b>CENIER FORT WASHINGTON HEALTH &amp; REHABILITATION</b>			4b. City, Town, or Location of Death <b>FORT WASHINGTON</b>			4c. County of Death <b>PRINCE GEORGES</b>			
Funeral Director	5. Social Security Number <b>250-46-7802</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUGUST 13, 1933</b>	9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>		
	Usual Residence of Decedent 10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>FORT WASHINGTON</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>407 HURTT PLACE</b>			10f. Zip Code <b>20744</b>			10g. Citizen of What Country? <b>UNITED STATES</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12TH GRADE</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>			16b. Kind of Business/Industry <b>HOME MAKER</b>			
	17. Father's Name (First, Middle, Last) <b>EZIEL HARRIS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CORA LEE ROBINSON HARRIS</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>WILLIE HILL, JR. / HUSBAND</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>407 HURTT PLACE, FORT WASHINGTON, MARYLAND 20744</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LOCKHART CHURCH CEMETERY</b>			Date	20c. Location - City or Town, State <b>SEPTEMBER 20, 2006 SALUDA, SOUTH CAROLINA</b>		
	21. Signature of Funeral Service Licensee <i>Lydia C. Thornton Johnson</i> <b>LYDIA C. THORNTON JOHNSON MO0583</b>			22. Name and Address of Facility <b>THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Atherosclerotic Heart Disease</b>								Approximate Interval Between Onset and Death	
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>									
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D42955</b>			29d. Date signed (Month, Day, Year) <b>8/14/06</b>				
	29b. Signature and title of certifier 		29c. License number <b>D42955</b>			29d. Date signed (Month, Day, Year) <b>8/14/06</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>EDGER POTTER, M.D. 11701 LIVINGSTON ROAD, SUITE #207, FORT WASHINGTON, MARYLAND 20744</b>									
	31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30841

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death	
	Odeill A. Jones				September 9 2006		1207 M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death	
	Anne Arundel Medical Center			Annapolis		Anne Arundel	
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Dec. 23 1917	9. Birthplace (State or Foreign Country) D.C.
	Usual Residence of Decedent 10a. State New York			10c. City, Town or Location White Plains			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 19 Van Buren Place			10f. Zip Code 10603			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 yrs.		16b. Kind of Business/Industry Secretary			State of New York
17. Father's Name (First, Middle, Last) John Carter Acty				18. Mother's Name (First, Middle, Maiden Surname) Alberta Carter			
19a. Informant's Name/Relationship (Type, Print) Pamela A. Wilson (Cousin)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 11708 Capstan Dr. Upper Marlboro, Md.			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fern Cliff Crematory		Date	20c. Location - City or Town, State 9/14/06 Greenbush, N.Y.		
21. Signature of Funeral Service Licensee <i>Larry G. Reese 100583</i>							
22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							
a. Due to (or as a consequence of): <i>Reval Farline</i>							
b. Due to (or as a consequence of): <i>Gastrointestinal Bleeding</i>							
c. Due to (or as a consequence of):							
d. _____							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 Natural <input type="checkbox"/> Pending investigation 2 Accident <input type="checkbox"/> Could not be determined 3 Suicide <input type="checkbox"/> 4 Homicide <input type="checkbox"/>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>M</i>				29c. License number <i>H53041</i>		29d. Date signed (Month, Day, Year) <i>9/9/06</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>D.R. Michael LaPenta</i> 2001 Medical Parkway Annapolis, MD 21401							
31. Date filed (Month, Day, Year) <i>SEP 13 2006</i>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. For  
State  
Registrar

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30842  
Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year			3. Time of Death		
<i>Mary Magaline Jones</i>		<i>Sept. 8, 2006</i>			<i>10:55 PM</i>		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death		
<i>Mallard Bay Care Center</i>		<i>Cambridge</i>			<i>Dorchester</i>		
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>82</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>April 21, 1924</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
Usual Residence of Decedent		10a. State <i>MD</i> 10b. County <i>Dorchester</i> 10c. City, Town or Location <i>Cambridge</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>412-Camper Street</i>		10f. Zip Code <i>21613</i>			10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Private Sitter</i>			16b. Kind of Business/Industry <i>Someone else's Home</i>		
17. Father's Name (First, Middle, Last) <i>Isaac Jones</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Evelyn Jones</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>412 Camper Street Cambridge, MD 21613</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Janelle C. Henry</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Pleasant Cemetery</i>			Date <i>9/16/06</i>	20c. Location - City or Town, State <i>Salem, Maryland</i>	
21. Signature of Funeral Service Licensee <i>Janelle C. Henry</i>		22. Name and Address of Facility <i>Henry Funeral Home, P.A. 510 Washington St, Cambridge, MD 21613</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, starting with the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death		
<p>a. Due to (or as a consequence of): <i>Anterior sclerotic Heart Disease</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
<p><i>Obstructive Sleep Apnea</i> <i>Chronic obstructive Airway Disease</i></p>					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <i>M</i> 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Mahbuba Akhter, M.D.</i>		
29b. Signature and title of certifier <i>M. Akhter, MD</i>		29c. License number <i>D63359</i>			29d. Date signed (Month, Day, Year) <i>9/12/06</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>300 AURORA STREET, CAMBRIDGE, MD 21613</i>							
31. Date filed (Month, Day, Year) <i>SEP 18 2006</i>		32. Registrar's Signature <i>[Signature]</i>					

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

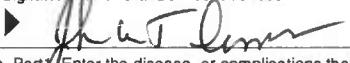
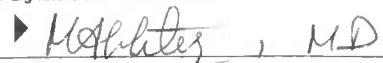
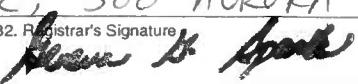
State of Maryland / Department of Health and Mental Hygiene

2006 30843

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Amos Calvert Jones</b>							2. Date of Death Month Day Year <b>September 7 2006</b>	3. Time of Death <b>4:40 p.m.</b>			
	4a. Facility Name (If not institution, give street and number) <b>Mallard Bay Care Center</b>				4b. City, Town, or Location of Death <b>Cambridge</b>			4c. County of Death <b>Dorchester</b>				
Funeral Director	5. Social Security Number <b>213-22-5438</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88 Yrs.</b>	If Under 1 Year Months <b>88</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>June 16, 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	10a. State <b>MD</b>				10b. County <b>Dorchester</b>				10c. City, Town or Location <b>Cambridge</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>520 Glenburn Avenue</b>				10f. Zip Code <b>21613</b>				10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>waterman</b>				16b. Kind of Business/Industry <b>seafood</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph Asbury Jones</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Daisy Wingate</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Roucelle N. Jones wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5325 Bucktown Road, Cambridge, MD 21613</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dorchester Memorial Park 9/11/06 Cambridge, MD</b>				Date	20c. Location - City or Town, State <b>Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613</b>		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	<p>a. <i>Arteriosclerotic Heart disease</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Pulmonary Embolism Seizure disorder</i>										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Did alcohol contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29b. Signature and title of certifier 		29c. License number <b>D0063359</b>				29d. Date signed (Month, Day, Year) <b>9/8/06</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARSHAL ACHTER, 300 AURORA ST, CAMBRIDGE MD- 21613</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>		32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30844

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Betty Jane Kidd</b>							2. Date of Death Month Day Year <b>September 25, 2006</b>	3. Time of Death 11:32 P M	
	4a. Facility Name (If not institution, give street and number) <b>49 South Market Street</b>			4b. City, Town, or Location of Death <b>Frederick</b>			4c. County of Death <b>Frederick</b>			
Funeral Director	5. Social Security Number <b>220-84-7565</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug. 4, 1923</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent <b>Maryland Frederick</b>		10a. State <b>Maryland</b> 10b. County <b>Frederick</b> 10c. City, Town or Location <b>Frederick</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>49 South Market Street</b>			10f. Zip Code <b>21701</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify:	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 7</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>			16b. Kind of Business/Industry <b>own home</b>			
	17. Father's Name (First, Middle, Last) <b>Charles Ezra Redmond</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edna Marie Winpigler</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Smith, daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 Old Oak Road, Thurmont, Maryland 21788</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Ryan N. Berger</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>			Date <b>9/30/2006</b>	20c. Location - City or Town, State <b>Frederick, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Ryan N. Berger</b>			22. Name and Address of Facility <b>Keeney and Basford Funeral Home</b>			M00999 106 East Church Street, Frederick, MD 21701			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Lung Cancer</b>								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <b>Lung Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	27. Manner of Death <b>'1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <b>Sajjad Aziz</b> MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <b>Sajjad Aziz MD</b>								29c. License number <b>D58391</b>	29d. Date signed (Month, Day, Year) <b>September 26, 2006</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sajjad Aziz, MD, 801 Toll House Avenue, C-3, Frederick, Maryland 21701</b>									
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature <b>James B. Greer</b>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural" or items 23a or 23b-1 show any injury or other traumatic event. The Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

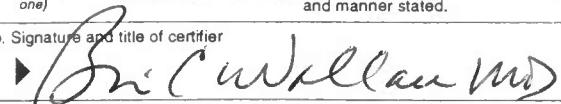
Medical Certification: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30845  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Lloyd Luke</b>							2. Date of Death Month Sep. Day 10, Year 2006	3. Time of Death 7:30p M
	4a. Facility Name (If not institution, give street and number) <b>Knollwood Manor Nursing Home</b>							4b. City, Town, or Location of Death <b>Millersville</b>	4c. County of Death <b>Anne Arundel</b>
Funeral Director	5. Social Security Number <b>215-01-3107</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 29, 1917</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Annapolis</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1103 Broadview Drive</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Builder</b>			16b. Kind of Business/Industry <b>Construction</b>		
	17. Father's Name (First, Middle, Last) <b>William Luke</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mamie Hummel</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>William I. Luke/Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>240 Elkins Lane Lusby, MD 20657</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hillcrest Mausoleum</b>			Date <b>Sept. 13, 2006</b>	20c. Location - City or Town, State <b>Annapolis, MD</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park, MD 21146</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Atherosclerotic Coronary Disease</b>								Approximate Interval Between Onset and Death <b>4 years</b>
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Due to (or as a consequence of): <b>a. Atherosclerotic Coronary Disease</b> b. _____ c. _____ d. _____								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <b>9 Unknown</b>			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE PROMYELOCYTIC LEUKEMIA</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>								28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>21236</b>
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 				29c. License number <b>D31136</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 11, 2006</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BRIAN C. WALLACE MD, 9005 KILBRIDGE RD., BALTIMORE, MD</b>								
	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30846  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia Marie McCormick</b>							2. Date of Death Month Day Year <b>September 22 2006</b>	3. Time of Death 1210 P M	
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital</b>			4b. City, Town, or Location of Death <b>Elkton</b>			4c. County of Death <b>Cecil</b>			
Funeral Director	5. Social Security Number <b>219-32-8203</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>June 14, 1935</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>225 West High Street</b>				10f. Zip Code <b>21921</b>				10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Assembler</b>				16b. Kind of Business/Industry <b>Electrical Motor Manufacturing</b>		
17. Father's Name (First, Middle, Last) <b>Everett Leroy Hall</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Marie Costello</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Davy G. McCormick/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>225 West High Street, Elkton, Maryland 21921</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Elkton Cemetery</b>			Date <b>September 27, 2006</b>	20c. Location - City or Town, State <b>Elkton, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Hicks Home for Funerals, P.A.</b>				22. Name and Address of Facility <b>103 W. Stockton Street, Elkton, Maryland 21921</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. <i>acute myocard infarction</i> Due to (or as a consequence of):</p> <p>b. <i>cardio renal insufficiency</i> Due to (or as a consequence of):</p> <p>c. <i>hypertension</i> Due to (or as a consequence of):</p> <p>d. <i>Hypotension</i></p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>JULIA CHIH HSU, MD</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JULIA CHIH HSU, MD. 223 west main st, ELKTON MD 21921</b>		29c. License number <b>DO4823</b>								
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		29d. Date signed (Month, Day, Year) <b>9/25/06</b>								
32. Registrar's Signature <b>Julia Chih Hsu</b>										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30847

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit document.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Carl V. Mulligan		September 16, 2006				11:20 PM M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Frostburg Village Nursing Care Center		Frostburg				Allegany	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 06-Jul-1921	9. Birthplace (State or Foreign Country) Maryland
10a. State Maryland		10c. City, Town or Location Mount Savage				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 16211 Calla Hill Road		10f. Zip Code 21545-				10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 clerk		16b. Kind of Business/Industry food market			
17. Father's Name (First, Middle, Last) James Mulligan		18. Mother's Name (First, Middle, Maiden Surname) Catherine Hiner					
19a. Informant's Name/Relationship (Type, Print) Margaret E. Mulligan wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16211 Calla Hill Road Mount Savage Maryland 21545				Date	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Saint Patrick's Cemetery		20c. Location - City or Town, State 20-Sep-2006 Mount Savage Maryland			
21. Signature of Funeral Service Licensee ▶ Gary Lynn Ranchy		22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 6 months					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Congestive Heart Failure Due to (or as a consequence of):					
		b. Due to (or as a consequence of):					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier ▶ wonsook shin MD					29c. License number D0055325
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOOK SHIN MD 48 Tarn Terrace Frostburg MD 21532		31. Date filed (Month, Day, Year) SEP 18 2006					32. Registrar's Signature ▶ k. jones
33. Date signed (Month, Day, Year) Sep 18, 2006							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

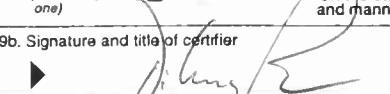
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30848

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arble Clifton Moyer							2. Date of Death Month Day Year <b>SEPTEMBER 15TH, 2006</b>	3. Time of Death 21:00
	4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>CUMBERLAND</b>			4c. County of Death <b>ALLEGANY</b>		
Funeral Director	5. Social Security Number <b>218-16-2669</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>03/05/1924</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Allegany</b>				10c. City, Town or Location <b>Flintstone</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>25609 Old Williams Road (P.O. Box 76)</b>				10f. Zip Code <b>21530</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembly Line</b>			16b. Kind of Business/Industry <b>Manufacturing</b>	
	17. Father's Name (First, Middle, Last) <b>Charles</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Moyer</b>			<b>Sarah VanMeter</b>	
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Hilda N. Moyer / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 76, Flintstone, Maryland 21530</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Vet. Cem @ Rocky Gap 09/18/2006</b>		Date <b>09/18/2006</b>	20c. Location - City or Town, State <b>Flintstone, MD</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <b>2 weeks</b>				
	<p>a. <b>Sepsis</b> Due to (or as a consequence of):</p> <p>{ b. _____ c. _____ d. _____</p>								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>POONAI, VIKRAMADITYA, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502</b>				31. Date filed (Month, Day, Year) <b>SEP 18 2006</b>		32. Registrar's Signature 		
	33. Date signed (Month, Day, Year) <b>September 18, 2006</b>								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

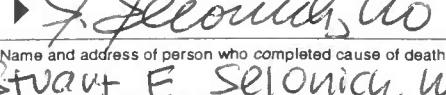
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No. 2006 30849

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Joyce Lindner Miller</b>						2. Date of Death Month Day Year <b>September 11 2006</b>		3. Time of Death <b>5:25 p M</b>		
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>			4b. City, Town, or Location of Death <b>Annapolis</b>				4c. County of Death <b>Anne Arundel</b>			
		5. Social Security Number <b>193-34-4439</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61 Yrs.</b>	If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) <b>Oct. 6 1944</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
		Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number <b>967 Ridgeway Drive</b>				10f. Zip Code <b>21409</b>			10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>5+</b>			16b. Kind of Business/Industry <b>Manager Library Services</b>				
		17. Father's Name (First, Middle, Last) <b>William Lindner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Krauss</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>Lawrence R. Miller (Husband)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>967 Ridgeway Drive, Annapolis, MD 21409</b>							
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>			Date <b>9-12-2006</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>			
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis MD 21401</b>							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of): <b>Lung cancer</b> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>1 yr, 8 mos</b>										
Medical Certification: To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		29b. Signature and title of certifier 			29c. License number <b>019838</b>				29d. Date signed (Month, Day, Year) <b>9/12/2006</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stuart E. Selonich, MD</b>			31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>				32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completed, it must be filed in the funeral director's name. It should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner shall be notified at once.

Baltimore, Maryland 21215-0036

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, file the Medical Examiner's report at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30850

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence G. Murray</b>					2. Date of Death Month <b>September</b> Day <b>7</b> Year <b>2006</b>	3. Time of Death 8:32P M	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>			4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>214-46-1567</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 7 1923</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10a. State <b>Maryland</b>	10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Bowie</b>					
	10e. Street and Number <b>13207 Falling Water Ct.</b>			10f. Zip Code <b>20720</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>0</b> <b>Homemaker</b>		16b. Kind of Business/Industry <b>None</b>			
	17. Father's Name (First, Middle, Last) <b>Frank Green</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Maggie Stevens</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Ella Sembly (Daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13207 Falling Water Ct. Bowie, Md. 20720</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Larry D. Reese m06483</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veteran</b>		Date <b>9-14-06</b>	20c. Location - City or Town, State <b>Crownsville, Md.</b>		
	21. Signature of Funeral Service Licensee <b>Wm. Reese &amp; Sons Mortuary, P.A.</b>			22. Name and Address of Facility <b>821 West ST. Annapolis, Md. 21401</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	<p>a. <b>Acute Renal Failure</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic renal failure</b> <b>Swallowing dysfunction</b>							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>00057635</b>				29d. Date signed (Month, Day, Year) <b>Sept. 07, 2006</b>	
	29b. Signature and title of certifier 							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Tim Woods 2001 medical parkway Annapolis MD 21401</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

## Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a, or 28e, show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar1- For  
State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 3085 |

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Miriam Martin</b>					2. Date of Death Month Day Year <b>September 13, 2006 10:00 AM</b>	3. Time of Death
	4a. Facility Name (If not institution, give street and number) <b>519 Valley Street</b>			4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>162-24-3548</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81 Yrs.</b>	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 26, 1924</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	10a. State <b>Maryland</b>			10b. County <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>519 Valley Street</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>3</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Reg. Nurse</b>			16b. Kind of Business/Industry <b>Industrial</b>	
17. Father's Name (First, Middle, Last) <b>Francis J. Homet</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Tyler</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Marilyn Lynerd/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>609 Charles St. Frederick, MD 21702</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Burial</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>frederick Crematory</b>		Date <b>9/15/2006</b>	20c. Location - City or Town, State <b>Frederick, MD 21702</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Parkinson</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Parkinson Disease</b>							
Approximate Interval Between Onset and Death <b>5-7 days</b>							
IF FEMALE:		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year <b>-</b>	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospital</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) <b>-</b>		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>-</b>				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>-</b>							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D57643</b>			
29b. Signature and title of certifier  <b>Shah Hiren, MD</b>				29d. Date signed (Month, Day, Year) <b>7/14/06</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>65 C Thomas Johnson Jr Frederick MD 21702</b>							
31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>							
32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30852  
Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death	
	Ralph LeRoy Martin							September 10, 2006			11:45 AM	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death				
	10620 Powell Road			Thurmont				Frederick				
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)					
214-34-0701			69 Yrs.			Oct. 15, 1936	Maryland					
Usual Residence of Decedent												
10a. State	10b. County	10c. City, Town or Location							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Maryland	Frederick	Thurmont										
10e. Street and Number			10f. Zip Code				10g. Citizen of What Country?					
10620 Powell Road			21788				United States					
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
Elementary/Secondary (0-12) 9		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
College (1-4 or 5+)					Heavy Equipment Operator			Concrete				
17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Surname)						
Elmer LeRoy Martin						Anna Belle Springer						
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Jean Wetzel / Daughter				21 Howard St., Apartment 4, Thurmont, MD 21788								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)				20c. Date				
				Resthaven Mem. Garden 9/14/2006				Frederick, Maryland				
21. Signature of Funeral Service Licensee <i>Courtney Stauffer</i>												
22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death) <i>Atherosclerotic Cerebrovascular Disease</i> Approximate Interval Between Onset and Death 20 yrs												
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
{ a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier <i>J.L. KRANTZ MD</i>												
29c. License number <i>0035152</i>												
29d. Date signed (Month, Day, Year) <i>9-12-06</i>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>J.L. KRANTZ MD 100 S. Cedar St Thurmont MD 21788</i>												
31. Date filed (Month, Day, Year) <i>SEP 15 2006</i>		32. Certifier's Signature <i>J.L. KRANTZ</i>										

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

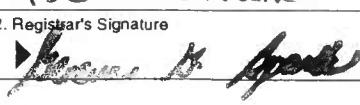
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2006 30853

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Walter Malinich</b>							2. Date of Death Month Day Year <b>September 9, 2006</b>	3. Time of Death M <b>4:00 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>421 South Main Street</b>			4b. City, Town, or Location of Death <b>Hurlock</b>			4c. County of Death <b>Dorchester</b>		
Funeral Director	5. Social Security Number <b>105-14-8256</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Jan. 13, 1919</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Hurlock</b>			10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>421 South Main Street</b>			10f. Zip Code <b>21643</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Security Guard</b>			16b. Kind of Business/Industry <b>Technology Corporation</b>		
	17. Father's Name (First, Middle, Last) <b>Frank Malinich</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Cbirk</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Juanita Malinich/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>421 South Main Street, Hurlock, Maryland 21643</b>				
	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crematory of Delmarva</b>			Date <b>9/11/2006</b>	20c. Location - City or Town, State <b>Delmar, Delaware</b>		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Probable myocardial infarction</b>								Approximate Interval Between Onset and Death
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.      								Oid tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>
	23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>		23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	23e. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> D.O.A Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>			
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day Year) <b>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Preston MD 21655</b>			
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29c. License number <b>DOOS3255</b>					29d. Date signed (Month, Day, Year) <b>9/11/06</b>	
	29b. Signature and title of certifier 								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Melinda Butler 136 Rednum Ave Preston MD 21655</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 						

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No.

2006 30854

**Baltimore, Maryland 21215-0036**

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>George Brian Murphy, Jr.</b>							2. Date of Death Month Day Year <b>September 11, 2006</b>	3. Time of Death <b>2:22 p M</b>
	4a. Facility Name (If not institution, give street and number) <b>12008 Judson Road</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>	
<b>Funeral Director</b>	5. Social Security Number <b>214-88-9283</b>		6. Sex <b>1 X M 2 □ F</b>	7. Age (in yrs. last birthday) <b>45 Yrs.</b>		If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Dec. 3, 1960</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <b>1 □ Yes 2 X No</b>
10e. Street and Number <b>12008 Judson Road</b>					10f. Zip Code <b>20902</b>			10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4</b>			16b. Kind of Business/Industry <b>St. Anselm's Abbey School</b>				
17. Father's Name (First, Middle, Last) <b>George Brian Murphy, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Anne M. Crilly</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Karen Collins Murphy / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12008 Judson Road, Silver Spring, MD 20902</b>					
20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>			Date <b>Sept. 14, 2006</b>	20c. Location - City or Town, State <b>Silver Spring, Maryland</b>	
21. Signature of Funeral Service Licensee <b>► Richard Z Liles</b>				22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
<p>a. <b>Colon Cancer With Liver Metastasis</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
<p>Approximate Interval Between Onset and Death <b>9 Months</b></p> <p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown</p> <p>23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) _____</p> <p>23d. Date of delivery Month Day Year</p>									
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown</p> <p>24a. Was an autopsy performed? 1 □ Yes 2 X No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No</p>									
25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)							
27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>► David Perry, M.D.</b>		29c. License number <b>D18561</b>				29d. Date signed (Month, Day, Year) <b>September 12, 2006</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Perry, M.D. 110 Irving Street, NW, Washington, DC 20010</b>									
31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>		32. Registrar's Signature <b>Boone D. Spangler</b>							

Division of Vital Records, P.O. Box 68760,

**To The Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, *i.e. Medical Examiner must be notified at once*.

Baltimore, Maryland 21213-0036

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2006 30855

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death				
		Thomas	Month Day Year					
		4a. Facility Name (If not institution, give street and number)	Naill					
		The Johns Hopkins Hospital	Baltimore City					
Funeral Director		4b. City, Town, or Location of Death	4c. County of Death					
		Baltimore City	Baltimore City					
		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)				
		220-34-0348	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	67 Yrs.				
		If Under 1 Year Months	If Under 24 Hrs. Days	Hours Min.				
		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)					
		JAN. 6, 1939	Maryland					
Usual Residence of Decedent		10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits			
		Maryland	Frederick	Mount Airy	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?				
		14335 Peddicord Road	21771	United States				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.				
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	Specify: White				
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry					
Elementary/Secondary (0-12) 10		College (1-4 or 5+)	Painter	Painting Contractor				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)						
Clarence Naill		Myrtle Runkles						
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Ruth Naill / Wife		14335 Peddicord Rd./ Mount Airy, MD 21771	Date	20c. Location - City or Town, State				
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)						
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Locust Grove Cem.	09/18/2006	Mount Airy, Maryland				
21. Signature of Funeral Service Licensee		22. Name and Address of Facility	Stauffer Funeral Homes, P.A.					
Raymond Peterson		8 E. Ridgeville Blvd./ Mt. Airy, MD	21771					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death						
Immediate Cause (Final disease or condition resulting in death)		a. Asystolic Cardiac Arrest Due to (or as a consequence of):	1 hour					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Coronary Artery Disease Due to (or as a consequence of):	10 years					
{		c. Diabetes Mellitus Due to (or as a consequence of):	days					
d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown	3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)	23d. Date of delivery	Month	Day	Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?						
End Stage Renal Disease		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner?		26. Place of Death (Check only one)						
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one)		29b. Signature and title of certifier						
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number						
		29d. Date signed (Month, Day, Year)						
29b. Signature and title of certifier		29c. License number						
Bruce Rarley		29d. Date signed (Month, Day, Year)						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		9/18/06						
Bruce Rarley 600 North Wolfe St. Baltimore, Maryland 21202								
31. Date filed (Month, Day, Year)		32. Registrar's Signature						
SEP 15 2006		Karen & Bruce						
State Registrar								

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death,  
to the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

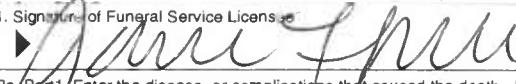
**Important:** If Item 27 is marked other than "natural", or Item 28a or 28a-1 how any injury or other traumatic event, **the Medical Examiner must be notified**.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend Item 29d per Dr., G859, 09/28/06dhb  
Certificate of Death

2006 30856  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy A. Norwood</b>				2. Date of Death Month Day Year <b>Sep 14, 2006</b>		3. Time of Death 7:20am M		
	4a. Facility Name (If not institution, give street and number) <b>Cumberland Nursing Center</b>		4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>				
Funeral Director	5. Social Security Number <b>262-71-9260</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Mar 19, 1922</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Allegany</b>				10c. City, Town or Location <b>LaVale</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>300 National Highway Apt. M</b>			10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Howard Vincent Brockey</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Essie C. (Bramble) Brockey</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Billie Williams</b> daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25617 Old Williams Rd Flintstone MD 21530</b>			Date <b>9/18/2006</b>	20c. Location - City or Town, State <b>Flintstone MD</b>		
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Rocky Gap Veterans Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Location - City or Town, State <b>Flintstone MD</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A.</b> <b>108 Virginia Avenue, Cumberland, MD 21502</b>			Approximate Interval Between Onset and Death <b>Free neut</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease condition resulting in death)		23b. Due to (or as a consequence of): <b>Metastatic colon cancer</b>						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): 23d. Date of delivery Month Day Year						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
			29c. License number <b>D46346</b>						
			29d. Date signed (Month, Day, Year) <b>September 16, 2006</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Huma Shakil M.D.</b>		31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>						
			32. Registrar's Signature 						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2006 30857

For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or Name 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 9 Day 13 Year 06		3. Time of Death 5:45A.M.
Angeline T Orbelio		4a. Facility Name (If not institution, give street and number) Autumn Ass't Living		4b. City, Town, or Location of Death Hagerstown
4c. County of Death Washington		5. Social Security Number 014-07-2327		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F
7. Age (In yrs, last birthday) 89 Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) 11/26/1917
Usual Residence of Decedent		10a. State MD		10b. County Washington
10c. City, Town or Location Hagerstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 310 Cameo Drive		10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER
16b. Kind of Business/Industry HOME MAKER		17. Father's Name (First, Middle, Last) Angelo Allegretto		18. Mother's Name (First, Middle, Maiden Surname) Theresa Giannotti
19a. Informant's Name/Relationship (Type, Print) James Harbell, Sr. Nephew		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13006 Point Salem Rd, Hagerstown, MD 21790		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Saint Michael's Cemetery		20c. Date - Date of Disposition 09-18-06
21. Signature of Funeral Service Licensee John R. Raduit		22. Name and Address of Facility Durst Funeral Home, Frostburg, MD 21532		20c. Location - City or Town, State Frostburg, Maryland
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Hyperensive cardiovascular disease		Approximate Interval Between Onset and Death 20Y
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): Dementia		10Y
24. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Ass. Hsg.		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number DS2323
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. WATSON MD 1126 0PAC CT HAGERSTOWN MD 21740		31. Date filed (Month, Day, Year) SEP 14 2006		29d. Date signed (Month, Day, Year) 9/13/06
32. Registrar's Signature 				

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30858

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Mary Ann Paddy</i>						2. Date of Death Month <input checked="" type="checkbox"/> Sep Day <input checked="" type="checkbox"/> 11 Year <input checked="" type="checkbox"/> 2006	3. Time of Death <i>633A M</i>
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Center</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>216-80-6706</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>52 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>Nov 20 1953</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
To Be Completed by Funeral Director	10a. State <i>MD</i> 10b. County <i>Anne Arundel</i> 10c. City, Town or Location <i>Edgewater</i>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <i>1624 Marlboro Road</i>			10f. Zip Code <i>21037</i>			10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>19XX</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 10</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Own Home</i>		
	17. Father's Name (First, Middle, Last) <i>Alfred Lee Howard</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Lucille Howes</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Larry E. Paddy (Husband)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1624 Marlboro Road, Edgewater, MD 21037</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>St. James Cemetery</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>St. James Cemetery</i>		Date <i>9-15-2006</i>	20c. Location - City or Town, State <i>Lothian, MD</i>		
	21. Signature of Funeral Service Licensee <i>J. G. C.</i>		22. Name and Address of Facility <i>Hardesty Funeral Home, P.A. 905 Galesville Road, Galesville, MD 20765</i>					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Pneumonia</i>						Approximate Interval Between Onset and Death <i>1 month</i>	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
	23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diverticulitis Sacral decubitus ulcer</i>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29c. License number <i>P18587</i>	29d. Date signed (Month, Day, Year) <i>Sep 11, 2006</i>
	30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) <i>Jonathan Fenkel, MD 22 S. Greene Street, Suite N3E10, Baltimore, MD 21201</i>							
	31. Date filed (Month, Day, Year) <i>SEP 13 2006</i>		32. Registrar's Signature <i>Jonathan Fenkel</i>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30859

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

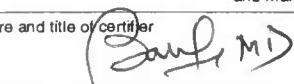
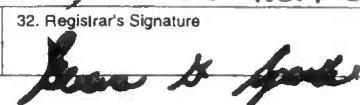
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
MARY ETHELYNE PAYNE PILCHARD		Sept. 13, 2006		9:50 p M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Hartley Hall Nursing Home		Pocomoke City		Worcester	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 16, 1909	9. Birthplace (State or Foreign Country) Maryland
212-10-2313A					
Usual Residence of Decedent					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10a. State MD	10b. County Worcester	10c. City, Town or Location Pocomoke City			
10e. Street and Number 1006 Market Street		10f. Zip Code 21851		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry Retail
17. Father's Name (First, Middle, Last) Thomas James Payne			18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Redden		
19a. Informant's Name/Relationship (Type, Print) Carolyn Thompson (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Linden Ave., Apt. 107, Pocomoke City, MD 21851			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Cemetery		Date 9/18/2006	20c. Location - City or Town, State Girdletree, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<p>a. Vulvar Cancer Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>					
Approximate Interval Between Onset and Death 6 - months					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D54422		29d. Date signed (Month, Day, Year) 9-13-06	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604- Market St., Pocomoke, MD 21851					
31. Date filed (Month, Day, Year) SEP 15 2006		32. Registrar's Signature 			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30860

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William T Reihms</b>				2. Date of Death Month Day Year <b>September 24 2006</b>		3. Time of Death <b>05:24 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Chester River Hospital Center</b>		4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Kent</b>			
Funeral Director	5. Social Security Number <b>222-36-0914</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>11/4/1953</b>	9. Birthplace (State or Foreign Country) <b>Delaware</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>DE</b> 10b. County <b>Kent</b> 10c. City, Town or Location <b>Clayton</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>812 Holletts Corner Road</b>			10f. Zip Code <b>19938</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1968</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Hazardous Materials Truck Driver</b>		16b. Kind of Business/Industry <b>Transportation</b>			
	17. Father's Name (First, Middle, Last) <b>Charles E. Reihms</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Lee Pierson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Theresa M. Reihms/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>812 Holletts Corner Road Clayton, DE 19938</b>			
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>M00510</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Kent Cremation Services</b>		Date <b>10/1/2006</b>	20c. Location - City or Town, State <b>Smyrna, DE</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Fairies Funeral Directors, Inc.</b>				22. Name and Address of Facility <b>29 S. Main Street Smyrna, DE 19977</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <b>12 hrs.</b>			
	a. <b>Probable pulmonary embolism</b> Due to (or as a consequence of): <b>Myocardial infarction</b> Due to (or as a consequence of): <b>Acute renal failure</b> Due to (or as a consequence of): <b>Acute coagulopathy</b>				<b>10 hrs.</b>			
	b. <b>Chronic hypertension</b> Due to (or as a consequence of): <b>Cardiac failure</b>				<b>8 hrs.</b>			
	c. <b>Chronic renal failure</b> Due to (or as a consequence of): <b>Acute coagulopathy</b>				<b>10 hrs.</b>			
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cont'd Hypertension Card</b>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>SEP 28 2006</b>		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29d. Date signed (Month, Day, Year) <b>9/24/10</b>			
	29b. Signature and title of certifier <b>MD</b>				29c. License number <b>D51735</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frederick Delboy MD 6602 Church Hill Road Chestertown MD 21620</b>							
	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Leanne A. Foster</b>					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

John Francis Ruetten, Jr.

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30861

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

John Francis Ruetten, Jr.

2. Date of Death

Month Day Year  
September 18, 2006

3. Time of Death

0726 hrs

**Funeral  
Director**

4a. Facility Name (if not institution, give street and number)

6922 Fish Hatchery Road

4b. City, Town, or Location of Death

Frederick 21702

4c. County of Death

Frederick

5. Social Security Number  
216-64-13426. Sex  
 M  F7. Age (In yrs. last birthday)  
53 Yrs.If Under 1 Year  
Months Days Hours Min.8. Date of Birth (MM/DD/YYYY)  
Oct. 9, 19529. Birthplace (State or  
Foreign Country) Virginia

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick10c. City, Town or Location  
Frederick10d. Inside City Limits  
 Yes  No

10e. Street and Number

6922 Fish Hatchery Road

10f. Zip Code  
2170210g. Citizen of What Country?  
USA

11. Marital Status

1  Never Married  
2  Married  
3  Widowed  
4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes  
2  No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1  Yes  
2  No  
Specify14. Race - American Indian, Black, White, etc.  
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Painter

16b. Kind of Business/Industry  
Commercial

17. Father's Name (First, Middle, Last)

John F. Ruetten, Sr.

18 Mother's Name (First, Middle, Maiden Surname)

Lorraine Lewandowski

19a. Informant's Name/Relationship (Type, Print)

William H. Ruetten/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6922 Fish Hatchery Road, Frederick, MD 21702

20a. Method of Disposition

1  Burial  
2  Cremation  
3  Removal from State  
4  Donation  
5  Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

Frederick Crematory

Date

20c. Location - City or Town, State

9/22/2006 Frederick, MD 21702

21. Signature of Funeral Service Licensee

Rogelio M. Miller

22. Name and Address of Facility

Stauffer Funeral Home, PA  
1621 Opossumtown Pike, Frederick, MD 21702

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**To Be Completed by Funeral Director**

23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastrointestinal hemorrhage due to liver cirrhosis

Approximate Interval Between Onset and Death

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

item#23a,27,perME,g860, 10/2/06 TT

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes  
2  No  
9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth  
2  Fetal death  
3  Ectopic pregnancy  
4  Pregnant at time of death  
5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?

1  Yes  
2  No

26. Place of Death (Check only one)

Hospital 1  Inpatient 2  ER/Outpatient 3  DOA 4  Nursing Home 5  Residence 6  Other Scene

27. Manner of Death

1  Natural  
2  Accident  
3  Suicide  
4  Homicide  
5  Pending Investigation  
6  Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc  
(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated  
one  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

29b. Signature and title of certifier

Ana Rubio MD

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29c. License number  
O.C.M.E.

29d. Date signed (Month, Day, Year)

September 19, 2006

31. Date filed (Month, Day, Year)

SEP 25 2006

32. Registrar's Signature  
Ana Rubio**State  
Registrar**

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30862

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Chandus Thomas Rippons, Jr.</b>							2. Date of Death Month Day Year <b>Sept. 8, 2006</b>		3. Time of Death 1520 M		
	4a. Facility Name (If not institution, give street and number) <b>Dorchester General Hospital</b>			4b. City, Town, or Location of Death <b>Cambridge</b>			4c. County of Death <b>Dorchester</b>					
Funeral Director	5. Social Security Number <b>216-40-4144</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>March 5, 1941</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
Usual Residence of Decedent										10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Hoopersville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>1841 Hoopersville Rd.</b>					10f. Zip Code <b>21634</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Operator</b>			16b. Kind of Business/Industry <b>Seafood</b>						
	17. Father's Name (First, Middle, Last) <b>Chandus Thomas Rippons, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Ruark</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Charlotte L. Rippons/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1841 Hoopersville Rd., Hoopersville, MD 21634</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DorchesterMemorialPark</b>			Date <b>9/12/2006</b>		20c. Location - City or Town, State <b>Cambridge, MD</b>				
	Signature of Funeral Service Licensee <i>Helen Farren Grinnell</i>											
	22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										22. Name and Address of Facility <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613</b>	Approximate Interval Between Onset and Death <b>ten years</b>
	<p>a. <i>Coronary artery disease</i> Due to (or as a consequence of):</p> <p>b. <i>Atrial fibrillation</i>. Due to (or as a consequence of):</p> <p>c. <i>Hypertension</i>. Due to (or as a consequence of):</p> <p>d.</p>											
Physician /Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>								28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Cambridge, MD 21613</b>	
	29b. Signature and title of certifier <i>Vinodrai Mehta</i>		29c. License number <b>D15541</b>								29d. Date signed (Month, Day, Year) <b>9/13/2006</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Vinodrai Mehta, 402 Byrn St., Cambridge, MD 21613</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature <i>James A. Jones</i>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30863  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death	
	Mary L. Stradford							Sept. 16, 2006			9:35P M	
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death			
	Pineview Future Care Nursing Center Clinton								Prince Georges			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)					
579-24-1043		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	86 Yrs.			Feb. 14, 1920	SC					
Usual Residence of Decedent												
10a. State	10b. County		10c. City, Town or Location							10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Md.	PG		Fort Washington									
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?				
811 Lira Drive				20744				United States				
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced												
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry				
Elementary/Secondary (0-12)		College (1-4 or 5+)		Teacher				DC School System				
4+												
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)							
Daniel Valentine					Rosa E. Dozier							
19a. Informant's Name/Relationship (Type, Print)												
Tyrone Stradford/son												
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
811 Lira Drive Fort Washington, Md. 20744												
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)												
20b. Place of Disposition (Name of cemetery, crematory or other place) Date Harmony Mem. Park 9/22/06 Landover, Md												
20c. Location - City or Town, State												
21. Signature of Funeral Service Licensee Janice Edwards												
22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death)												
a. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> YEARS Due to (or as a consequence of):												
b. Due to (or as a consequence of):												
c. Due to (or as a consequence of):												
d.												
Approximate Interval Between Onset and Death												
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <u>P. Wisorsky M.D.</u>												
29c. License number <u>D-18545</u>												
29d. Date signed (Month, Day, Year) <u>SEPTEMBER 21, 2006</u>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>P. Wisorsky M.D. 12070 OLD LINE CENTER WALDORF, MD 20602</u>												
31. Date filed (Month, Day, Year) <u>SEP 28 2006</u>												
32. Registrar's Signature <u>John B. Smith</u>												

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: if Item 27 is marked other than "natural" or items 23a or 28-f show any injury or other traumatic event. The Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30864

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Teri Dawn Stephens</b>					2. Date of Death Month <b>09</b> Day <b>14</b> Year <b>06</b>		3. Time of Death <b>0152 M</b>
	4a. Facility Name (If not institution, give street and number) <b>WMHS Braddock Campus</b>					4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>ALLEGANY</b>
Funeral Director	5. Social Security Number <b>286-88-4947</b>	6. Sex <b>1 □ M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>34 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>9-14-1972</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
To Be Completed by Funeral Director	10a. State <b>MD</b> 10b. County <b>Allegany</b>					10c. City, Town or Location <b>Corriganville</b>		10d. Inside City Limits <b>1 <input checked="" type="checkbox"/> Yes 2 □ No</b>
	10e. Street and Number <b>10810 Lowery Lane</b>					10f. Zip Code <b>21524</b>	10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1 □ Never Married 2 <input checked="" type="checkbox"/> Married 3 □ Widowed 4 □ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 <input checked="" type="checkbox"/> No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Waitress</b>		16b. Kind of Business/Industry <b>Restaurant</b>			
	17. Father's Name (First, Middle, Last) <b>Ronald E. Riggs</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Faye Ann Lowery</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mark Stephens / Husband</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO Box 33, Corriganville, MD 21524</b>		
Physician /Medical Examiner	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 □ Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 □ Donation 5 □ Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Porter Cemetery</b>		Date <b>9-18-2006</b>	20c. Location - City or Town, State <b>Hyndman, PA</b>		
	21. Signature of Funeral Service Licensee <b>▶ Jeremy W. Heiter</b>					22. Name and Address of Facility <b>Harvey H. Zeigler Funeral Home 169 Clarence St., Hyndman, PA 15545</b>		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Refractory Hodgkin's lymphoma</b>					Approximate Interval Between Onset and Death <b>1 year</b>		
	<p>a. Due to (or as a consequence of): <b>Refractory Hodgkin's lymphoma</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No 9 □ Unknown</b>		23c. If yes, outcome of pregnancy <b>1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown</b>		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 □ No 3 □ Probably 4 <input checked="" type="checkbox"/> Unknown</b>		
						24a. Was an autopsy performed? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>		
						24b. Were autopsy findings available prior to completion of cause of death? <b>1 □ Yes 2 □ No</b>		
	25. Was case referred to medical examiner? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 □ ER/Outpatient 3 □ DDA</b> Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>					
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide</b>		28a. Date of Injury (Month, Day Year) <b>M</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 □ Yes 2 □ No</b>	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Cumberland</b>			
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>							
	29b. Signature and title of certifier <b>▶ AFAQ AHMAD</b>		29c. License number <b>D60478</b>		29d. Date signed (Month, Day, Year) <b>09/14/06</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AFAQ AHMAD 625 Kent Avenue #102 Johnson Heights Building, Cumberland</b>							
	31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>		32. Registrar's Signature <b>▶ AFAQ AHMAD</b>					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. All this certificate has been signed by the attending physician and completely filled in by the funeral director; page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

5  
T.T.  
T.M.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30865

Certificate of Death

Reg. No.

1- For  
State  
Registrar

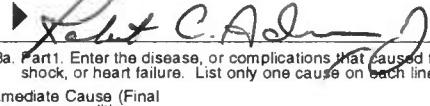
Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Jonas Edward Self			September 17, 2006 8:40 P M	
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death	
Devlin Manor Health Care Center			Cumberland	
4c. County of Death			Allegany	
5. Social Security Number			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.
215-18-8211			86	If Under 1 Year Months Days Hours Min.
10a. State MD			10b. County Allegany	
10c. City, Town or Location Black Valley Road			10f. Zip Code 21530	
10e. Street and Number			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
Elementary/Secondary (0-12) 6		15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer
17. Father's Name (First, Middle, Last) George Edward Self			18. Mother's Name (First, Middle, Maiden Surname) Lula Nelson	
19a. Informant's Name/Relationship (Type, Print) Earl Self / brother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21000 Creek Road, Flintstone, Maryland 21530	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Glendale Cemetery	Date 09/23/2006
21. Signature of Funeral Service Licensee 			20c. Location - City or Town, State Flintstone, MD	
22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, * any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Due to (or as a consequence of): <i>Lung cancer metastatic</i> 3 mm</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD</i>				
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 			29c. License number D17565	
29d. Date signed (Month, Day, Year) September 18, 2006				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony J. Bollino, Jr., MD, 922 National Highway, LaVale, MD 21502				
31. Date filed (Month, Day, Year) SEP 18 2006		32. Registrar's Signature 		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30866

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM HENRY SANGED</b>							2. Date of Death Month Day Year <b>SEPTEMBER 8, 2006</b>	3. Time of Death 7:05 P M
	4a. Facility Name (If not institution, give street and number) <b>ST VINCENT de PAUL NURSING CENTER</b>				4b. City, Town, or Location of Death <b>FROSTBURG</b>			4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>216-14-1910</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>18-Jan-1923</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b>				10b. County <b>Allegany</b>			10c. City, Town or Location <b>Frostburg</b>	
10e. Street and Number <b>29 South Water Street</b>				10f. Zip Code <b>21532-</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
To Be Completed by Funeral Director	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>0</b>		16b. Kind of Business/Industry <b>clerk</b>			16c. Kind of Business/Industry <b>liquor store</b>	
17. Father's Name (First, Middle, Last) <b>George Sanged</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Hammond</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Elizabeth Myers</b> sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>29 S. Water Street</b> Frostburg Maryland 21532				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Frostburg Memorial Park</b>				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
<p>a. <b>Advanced Dementia</b> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					<p>Approximate Interval Between Onset and Death <b>2 years</b></p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				
					23d. Date of delivery Month Day Year				
					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
					28d. Describe how injury occurred				
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier  <b>M.D.</b>					29c. License number <b>D0055325</b>			29d. Date signed (Month, Day, Year) <b>Sep 11, 2006</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WONSOOK SHIN MD 48 Turn Terrace Frostburg MD 21592</b>					32. Registrar's Signature 				
31. Date filed (Month, Day, Year) <b>SEP 11 2006</b>					33. Date signed (Month, Day, Year)				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2/10A  
JRE

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30867  
Reg. No.

1 - For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

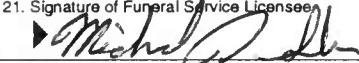
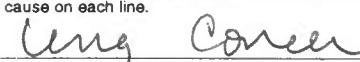
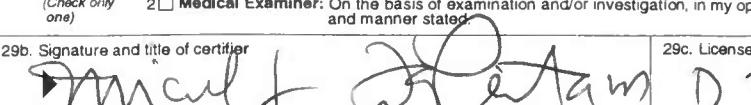
Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached (or use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		SINGER		2. Date of Death Month Day Year	3. Time of Death
FRANK S				09 07 2006	1410 M
4a. Facility Name (If not institution, give street and number)		Anne Arundel Medical Center		4b. City, Town, or Location of Death Annapolis	
5. Social Security Number 220-20-0779		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 25, 1928
Usual Residence of Decedent		10a. State Maryland		10c. City, Town or Location Annapolis	
10e. Street and Number 100 Carroll Drive		10f. Zip Code 21403		10g. Citizen of What Country? United States	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-1952		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Security Guard		16b. Kind of Business/Industry Security	
17. Father's Name (First, Middle, Last) Ferdinand B. Singer		18. Mother's Name (First, Middle, Maiden Surname) Clara Carroll			
19a. Informant's Name/Relationship (Type, Print) Bernadette Singer / Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98 Carroll Drive Annapolis, Maryland 21403			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville Vet. Cem		Date 9/13/2006	20c. Location - City or Town, State Crownsville, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 2 months			
a.  Due to (or as a consequence of):					
b. _____ Due to (or as a consequence of):					
c. _____ Due to (or as a consequence of):					
d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 214 38			
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) Sep 07 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL J. LATAM 445 DEFENSE HIGHWAY ANNAPOLIS MD		31. Date filed (Month, Day, Year) SEP 13 2006			
32. Registrar's Signature 		33. Date filed (Month, Day, Year) 2100			

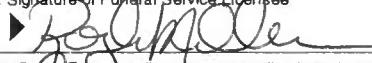
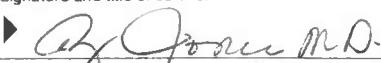
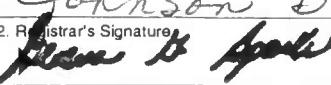
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30868  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death			
	Alexander Malcolm Shields, Jr.							September 12, 2006			5:45 A M			
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death						
	9 Glade Court			Walkersville				Frederick						
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)				
	139-20-2267			80 Yrs.					Sept. 28, 1925	New Jersey				
Usual Residence of Decedent														
10a. State		10b. County		10c. City, Town or Location								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Maryland		Frederick		Walkersville										
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?						
9 Glade Court				21793				United States						
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			14. Race - American Indian, Black, White, etc. Specify: White						
15. Decedent's Education (Specify only highest grade completed)		Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry						
					Engineer			Dept. of Defense						
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)									
Alexander M. Shields					Flora Maitland									
19a. Informant's Name/Relationship (Type, Print)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Jacqueline C. Shields/Wife					9 Glade Court, Walkersville, MD 21793									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State				
					Frederick Crematory			9/16/06		Frederick, Maryland				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Stauffer Funeral Home, PA 40 Fulton Avenue, Walkersville, MD 21793									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.														
Approximate Interval Between Onset and Death														
Immediate Cause (Final disease or condition resulting in death)					a. Congestive Heart Failure Due to (or as a consequence of):									
					b. Acute Myocardial Infarction Due to (or as a consequence of):									
					c. Bladder Cancer with metastasis Due to (or as a consequence of):									
					d.									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
Rectal Mass.														
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
							M							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number									
					MDD 32245									
29b. Signature and title of certifier 					29d. Date signed (Month, Day, Year)									
					9/14/06									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					32. Registrar's Signature 									
56 Thomas Johnson Dr. Frederick Md 21702														
31. Date filed (Month, Day, Year)					32. Registrar's Signature									
SEP 15 2006														

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30869

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	Stella Frances Serbent			September 12, 2006			9:48 A.M.		
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death	
	Sunrise of Montgomery Village				Montgomery Village			Montgomery	
Usual Residence of Decedent									
Maryland	10b. County		10c. City, Town or Location						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Montgomery				Montgomery Village					
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?	
10740 Wayridge Drive				20886				United States	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
Elementary/Secondary (0-12)		15. Decedent's Education (Specify only highest grade completed) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Home	
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)				
Gabriel Kiselius					Agnes Petraitis				
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
James J. Serbent/Son		10740 Wayridge Drive, Montgomery Village, MD. 20886							
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State		
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Metropolitan Crematory 9/12/2006					Alexandria, Virginia		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)									
a. Cerebrovascular Accident Due to (or as a consequence of):									
b. Temporel Arteritis Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d.									
Approximate Interval Between Onset and Death minutes									
yours									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Carotid Artery Stenosis									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Assisted Living							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 					29c. License number			29d. Date signed (Month, Day, Year)	
					D 60526			September 12, 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
Ayesha Jafri, M.D., 15201 Shady Grove Road, # 202, Rockville, Maryland 20850									
31. Date filed (Month, Day, Year)		32. Registrar's Signature 							
SEP 14 2006									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30870

Reg. No.

1- For  
State  
Registrar

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Erika Thimey</b>							2. Date of Death Month Day Year <b>Sept. 20, 2006</b>	3. Time of Death <b>8:15 A. M</b>
	4a. Facility Name (If not institution, give street and number) <b>Somerford Place</b>			4b. City, Town, or Location of Death <b>Hagerstown</b>			4c. County of Death <b>Washington</b>		
<b>Funeral Director</b>	5. Social Security Number <b>017-14-6489</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>March 12, 1910</b>	9. Birthplace (State or Foreign Country) <b>Germany</b>		
	Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>Washington</b>			10c. City, Town or Location <b>Smithsburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>12514 Bradbury Ave.</b>				10f. Zip Code <b>21783</b>		10g. Citizen of What Country? <b>U.S.A</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>12</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify:		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Instructor</b>		16b. Kind of Business/Industry <b>Dance School</b>					
17. Father's Name (First, Middle, Last) <b>Berthold Thimey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Charlotte Weber</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Emma Lou Davis Comstock P/R</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 215 Smithsburg, Md. 21783</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Smithsburg Crematory</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		Date <b>Sept. 24, 2006</b>	20c. Location - City or Town, State <b>Smithsburg, Md.</b>				
21. Signature of Funeral Service Licensee <b>Jeffrey Lee Davis MO1414</b>		22. Name and Address of Facility <b>J.L. Davis Funeral Home</b>		12525 Bradbury Ave. <b>Smithsburg, Md. 21783</b>					
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CONGESTIVE HEART FAILURE</b> <b>CHRONIC EDema</b>								Approximate Interval Between Onset and Death <b>YEARS</b>	
23b. Part II Enter the disease, or complications that contributed to death but not resulting in the underlying cause given in Part I. <b>MASTECTOMY - 1992</b> <b>BREAST CARCINOMA</b>								Approximate Interval Between Onset and Death <b>YEARS</b>	
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9 Unknown</b>		23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>L Wright Woodside</b>		29c. License number <b>00022043</b>		29d. Date signed (Month, Day, Year) <b>9/20/06</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>11110 MEDICAL CAMPUS RD HAGERSTOWN MD. 21742</b>		31. Date filed (Month, Day, Year) <b>SEP 28 2006</b> 32. Registrar's Signature <b>Maureen B. Gable</b>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

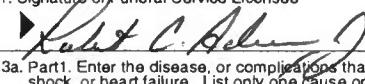
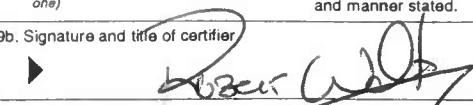
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30871

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Myrtle Elouise Trexler					2. Date of Death Month Day Year SEPTEMBER 15 2006	3. Time of Death 0045 M							
	4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>								
Funeral Director	5. Social Security Number 219-14-6044		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 04/25/1923	9. Birthplace (State or Foreign Country) Maryland							
	Usual Residence of Decedent		10a. State MD		10b. County Allegany		10c. City, Town or Location Mt. Savage		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 13915 Mt. Savage Road, NW				10f. Zip Code 21545		10g. Citizen of What Country? USA							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3 Nurse			16b. Kind of Business/Industry Hospital							
17. Father's Name (First, Middle, Last) Walter Garfield Robertson				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Emerick										
19a. Informant's Name/Relationship (Type, Print) Vaughn Trexler / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13915 Mt. Savage Road, NW, Mt. Savage, MD 21545										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Mem. Gardens		Date 09/18/2006	20c. Location - City or Town, State LaVale, MD							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): <b>PULMONARY EMBOLISM</b>			Approximate Interval Between Onset and Death 48 hours							
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year							
24. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
							28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 				29c. License number D31875			29d. Date signed (Month, Day, Year) SEPTEMBER 15 2006							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ROBERT WELIK 904 SETON DRIVE CUMBERLAND, MARYLAND 21502														
31. Date filed (Month, Day, Year) SEP 18 2006				32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be consulted at once.

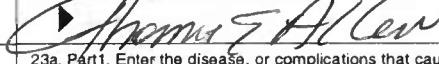
+10  
S.T.  
Mds

State  
Registrar

## Certificate of Death

Reg. No.

1-  
For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph Tominovich</b>							2. Date of Death Month Day Year <b>SEPTEMBER 6 2006</b>			3. Time of Death <b>3:23 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND MEDICAL SYSTEM</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death				
Funeral Director	5. Social Security Number <b>200-24-8190</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Nov. 20, 1932</b>	9. Birthplace (State or Foreign Country) <b>PA</b>					
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Howard</b>			10c. City, Town or Location <b>Elkridge</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>7815 Oxford Drive</b>				10f. Zip Code <b>21075</b>			10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1951-1955</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>2</b>		16b. Kind of Business/Industry <b>Chesapeake Electrical Systems, Inc.</b>								
17. Father's Name (First, Middle, Last) <b>Joseph Tominovich</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Scalet</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Helen M. Tominovich/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7815 Oxford Drive, Elkridge, MD 21075</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>		Date <b>Sep. 13, 2006</b>	20c. Location - City or Town, State <b>Crownsville, MD</b>							
21. Signature of Funeral Service Licensee 		22. Main address of Facility <b>Meadowridge Mem. Park</b>		Elkridge, MD								
		22. Main address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death								
<p>a. <b>STAPHYLOCOCCUS AUREUS BACTEREMIA / PNEUMONIA</b> Due to (or as a consequence of):</p> <p>b. <b>EMPYEMA</b> Due to (or as a consequence of):</p> <p>c. <b>PNEUMONECTOMY</b> Due to (or as a consequence of):</p> <p>d. <b>NON-SMALL CELL LUNG CANCER</b></p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier 				29c. License number <b>P17740</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 6, 2006</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAY DALAL 22 SOUTH GREENE STREET, BALTIMORE, MD 21201</b>												
31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature 										

**Baltimore, MD 21215-0036**

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

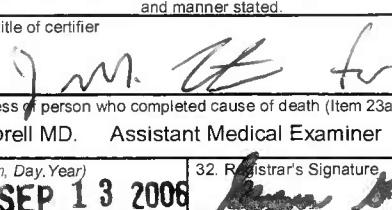
**Please Type or Print in Black Indelible Ink**

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2006 30873

Physician/ Medical Examiner		1- For State Registrar									
		1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death				
		<b>Raul Pelaez Torres</b>			Month Day Year September 9, 2006		2335 hrs				
Funeral Director		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death				
		160 Margate Drive			Glen Burnie		Anne Arundel				
To Be Completed by Funeral Director		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)		
		N/A		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	40 Yrs.	Months	Days	Hours	Min.	03/08/1966 Mexico	
		Usual Residence of Decedent									
		10a. State	10b. County	10c. City, Town or Location						10d. Inside City Limits	
		Maryland	N/A	Baltimore						<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
		415 Poppleton Street			21223			Mexico			
Physician /Medical Examiner		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
		1 <input type="checkbox"/> Never Married	2 <input checked="" type="checkbox"/> Married	1 <input type="checkbox"/> Yes	2 <input checked="" type="checkbox"/> No	1 <input checked="" type="checkbox"/> Yes	2 <input type="checkbox"/> No	specify: Mexican			Specify: White
		3 <input type="checkbox"/> Widowed		4 <input type="checkbox"/> Divorced	If Yes, Give Year or Dates:						
		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
		Elementary/Secondary (0-12) 6th			College (1-4 or 5+) Laborer			Construction			
Medical Certification: To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)						
		Raul Pelaez			Teresa Torres						
		19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
		Infante Torres/ Brother			415 Poppleton Street, Baltimore, MD 21223						
		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State			
		1 <input type="checkbox"/> Burial	2 <input type="checkbox"/> Cremation	3 <input checked="" type="checkbox"/> Removal from State	El Zapote San Miguel			9-14-06	San Miguel, Oaxaca		
		4 <input type="checkbox"/> Donation	5 <input type="checkbox"/> Other Specify:								
		21. Signature of Funeral Service Licensee			22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037						
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
		Approximate Interval Between Onset and Death									
		Immediate Cause (Final disease or condition resulting in death)			a. Multiple Injuries Due to (or as a consequence of):						
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			b. Due to (or as a consequence of):						
					c. Due to (or as a consequence of):						
					d. _____						
		<input type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED	item#1, perME, g860, 10/20/06 TT							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth      2 <input type="checkbox"/> Fetal death      3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death      5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
		1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	9 <input type="checkbox"/> Unknown							
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes			26. Place of Death (Check only one)			23e. Did tobacco use contribute to the cause of death?			
		2 <input type="checkbox"/> No			Hospital: 1 <input type="checkbox"/> Inpatient	2 <input type="checkbox"/> ER/Outpatient	3 <input type="checkbox"/> DOA	Other: 4 <input type="checkbox"/> Nursing Home	5 <input type="checkbox"/> Residence	6 <input checked="" type="checkbox"/> Other: Scene	
		27. Manner of Death 1 <input type="checkbox"/> Natural			28a. Date of Injury (Month, Day, Year) Sep 9, 2006	28b. Time of Injury 2320 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes	2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Passenger auto fixed object collision		
		2 <input checked="" type="checkbox"/> Accident									
		3 <input type="checkbox"/> Suicide			6 <input type="checkbox"/> Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street			28f. Location (Street and Number or Rural Route Number, City or Town, State) 160 Margate Drive, Glen Burnie, MD		
		4 <input type="checkbox"/> Homicide									
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Check only one)									
		2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier 			29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) September 10, 2006			
		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registrar		31. Date filed (Month, Day, Year) SEP 13 2006			32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2006 30874

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death X 18:20 P M
June Christopher Travers	September 5, 2006	

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Dorchester General Hospital	Cambridge	Dorchester

Funeral  
Director

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month Day Year) June 3, 1932	9. Birthplace (State or Foreign Country) Maryland
217-28-3705					

Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State MD	10b. County Dorchester	10c. City, Town or Location Cambridge				

10e. Street and Number 5416 Mallard Lane	10f. Zip Code 21613	10g. Citizen of What Country? USA
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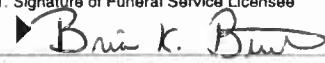
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) line worker	16b. Kind of Business/Industry electronics
College (1-4 or 5+)		

17. Father's Name (First, Middle, Last) James Stewart Christopher	18. Mother's Name (First, Middle, Maiden Surname) Mary Ida Thomas
--	--

19a. Informant's Name/Relationship (Type, Print) Cindy Baker daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5416 Mallard Lane, Cambridge, MD 21613
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20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Mem. Park	Date 9/9/06	20c. Location - City or Town, State Cambridge, MD
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust St., Cambridge, MD 21613
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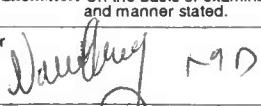
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Approximate Interval Between Onset and Death
a. Septicemic Due to (or as a consequence of): Gangrene left foot	
b. Due to (or as a consequence of): End stage renal disease	
c. Due to (or as a consequence of):	
d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

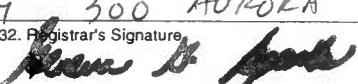
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
--	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	26. Place of Death (Check only one)
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27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier 	29c. License number D 47924	29d. Date signed (Month, Day, Year) 9-7-06
--	--	--------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORMAN THANAWLY 300 AURORA ST CAMBRIDGE MD 21613
--

31. Date filed (Month, Day, Year) SEP 07 2006	32. Registrar's Signature 
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #8 per phys/fh 09-15-Certificate of Death CMN

2006 30875  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Sept. Day 13, Year 2006	3. Time of Death 4:35 AM		
	ELDRED CHARLES VAN FOSSEN				4a. Facility Name (If not institution, give street and number) Beverly Health Care Center		4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick
Funeral Director	5. Social Security Number 220-18-0096	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month Oct. Day 25, Year 1925	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick	10c. City, Town or Location Frederick
10e. Street and Number 212 Wyngate Drive				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5		16b. Kind of Business/Industry Manager		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Remley		
17. Father's Name (First, Middle, Last) Eldred Winfield Van Fossen				19a. Informant's Name/Relationship (Type, Print) Margaret E. Van Fossen / Wife				
				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Wyngate Drive, Frederick, Maryland 21701				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date 9/16/06	20c. Location - City or Town, State Frederick, Maryland			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one in each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death END STAGE RENAL DISEASE						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
a. Due to (or as a consequence of): FAILURE TO THRIVE								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D 047951		29d. Date signed (Month, Day, Year) 9-14-2006				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sibte Kazmi, MD 814 Toll House Avenue, Frederick, Maryland 21701								
31. Date filed (Month, Day, Year) SEP 15 2006		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner or Trustee shall file a report within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner or Trustee shall file a report within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner or Trustee shall file a report within 24 hours after death.

State Registrar

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg No

2006 30876

**Physician/  
Medical Examiner**1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

**ADRIANUS DIDERIK PAUL VAN LITH**2 Date of Death  
Month Day Year  
September 10, 2006Time of Death  
1706 hrs**Funeral  
Director****To Be Completed by Funeral Director**

4a. Facility Name (if not institution, give street and number) <b>Route 301 @ Route 302</b>				4b. City, Town, or Location of Death <b>Church Hill</b>				4c. County of Death <b>Queen Anne's</b>	
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5. Social Security Number <b>051-30-1062</b>	6. Sex <b>1 X M 2 F</b>	7. Age (In yrs. last birthday) <b>78</b>	Yrs.	If Under 1 Year Months	If Under 24hrs Days	8. Date of Birth (MM/DD/YYYY) <b>06/11/1928</b>	9. Birthplace (State or Foreign Country) <b>GERMANY</b>
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10a. State <b>MD</b>				10b. County <b>DORCHESTER</b>				10c. City, Town or Location <b>FISHING CREEK</b>		10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 X No</b>
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10e. Street and Number <b>1512 TOM POINTE RD.</b>				10f. Zip Code <b>21634</b>				10g. Citizen of What Country? <b>USA</b>	
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1972-1989</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry <b>DOCTOR - INTERNAL MEDICINE MEDICAL</b>
		<b>5+</b>	

17. Father's Name (First, Middle, Last) <b>ADRIAAN PIETER VAN LITH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARTHA HELENA LAURA TITTELBACH</b>			
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19a. Informant's Name/Relationship (Type, Print) <b>KATHLEEN VAN LITH / DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8471 COLFAX COURT, JACKSONVILLE, FL 32244</b>			
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATION</b>	Date	20c. Location - City or Town, State <b>09/15/2006 STEVENSVILLE, MD</b>
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619</b>
---	--

23a. Part I Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)	a <b>Multiple Injuries</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	d. Due to (or as a consequence of):	

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I			
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene				
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month Day Year) <b>Sep 10, 2006</b>	28b. Time of Injury <b>1653 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Driver auto auto collision</b>
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Major Road / Highway</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Route 301 @ Route 302, Church Hill, MD</b>
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29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 11, 2006</b>
---	--	--

30. Name and address of person who completed cause of death (Item 23a) <b>Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>
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31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>	32. Registrar's Signature 
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Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 2 should be detached for use as the burial - transit

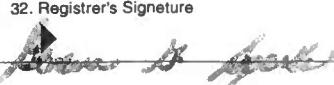
**Medical Certification: To Be Completed by Physician/Medical Examiner**

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30877

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ray Isham Vernon</b>							2. Date of Death Month Day Year <b>Sept. 14, 2006</b>	3. Time of Death <b>11:15 P.M.</b>	
	4a Facility Name (If not institution, give street and number) <b>Caroline Nursing Home</b>				4b. City, Town, or Location of Death <b>Denton</b>		4c. County of Death <b>Caroline</b>			
Funeral Director	5. Social Security Number <b>217-38-8060</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months <b>N/A</b>	If Under 24 Hrs. Hours <b>N/A</b>	8. Date of Birth (Month, Day, Year) <b>7-31-41</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Md.</b> 10b. County <b>Caroline</b> 10c. City, Town or Location <b>Marydel</b>								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>17291 Coolspring Rd.</b>				10f. Zip Code <b>21649</b>			10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>N/A</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 1 Welder</b>					16b. Kind of Business/Industry <b>Manufacturing</b>		
	17. Father's Name (First, Middle, Last) <b>Ray Vernon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Flossie Kovell</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Rae E. Vernon wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17291 Coolspring Rd. Marydel Md. 21649</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Cremation Ctr.</b>		Date <b>9-16-06</b>	20c. Location - City or Town, State <b>Chester Md.</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>P.O. Box 160 Fleegle-Helfenbein Greensboro Md. 21639</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>metastatic Non small cell lung cancer</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
	b. _____ Due to (or as a consequence of):									
	c. _____ Due to (or as a consequence of):									
	d. _____ Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 		29c. License number <b>251639</b>		29d. Date signed (Month, Day, Year) <b>9-15-06</b>					
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Karen Moffett 609 Daffin Ln. Denton Md. 21628</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 18 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: This law requires that the death certificate be a sealed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30878

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KAILEY AVA WILSON</b>				2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2006</b>	3. Time of Death <b>4:18 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST</b>		4b. City, Town, or Location of Death <b>ROCKVILLE, MARYLAND</b>		4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>123-45-6789</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>39</b>	If Under 1 Year Months <b>39</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>07/22/2006</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	10a. State <b>MD</b>		10b. County <b>FREDERICK</b>	10c. City, Town or Location <b>2550 EMERSON DRIVE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>FREDERICK, MARYLAND</b>			10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Year</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INFANT</b>		16b. Kind of Business/Industry <b>INFANT</b>				
17. Father's Name (First, Middle, Last) <b>TAYLOR L. WILSON</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>AISHA A. GREEN</b>					
19a. Informant's Name/Relationship (Type, Print) <b>AISHA GREEN/MOTHER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2550 EMERSON DRIVE, FREDERICK, MD</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>STERI CYCLE</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>STERI CYCLE</b>		Date <b>09/29/2006</b>	20c. Location - City or Town, State <b>HALL RIVER, NC</b>		
21. Signature of Funeral Service Licensee <b>Deborah A. Green</b>			22. Name and Address of Facility <b>SGAH, 9901 MEDICAL CENTER DR, ROCKVILLE</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseases or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>20 days</b>	
<p>a. <b>severe Pulmonary interstitial Emphysema</b> Due to (or as a consequence of):</p> <p>b. <b>severe bronchopulmonary dysplasia</b> Due to (or as a consequence of):</p> <p>c. <b>Extreme prematurity</b> Due to (or as a consequence of):</p> <p>d. <b>cmv pneumonia</b></p>							<b>20 days</b>	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month <b>09</b> Day <b>29</b> Year <b>2006</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>43225</b>			29d. Date signed (Month, Day, Year) <b>August, 30, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MADHUE NIGAM, M.D. Neonatologist Shady Grove Adventist Hospital</b>								
31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>			32. Registrar's Signature <b>Deborah A. Green</b>					

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at [redacted]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)	Jonathan Thomas Waltemeyer				2. Date of Death Month 8	Day 5	Year 2006	3. Time of Death 7:30 PM		
4a. Facility Name (If not institution, give street and number)	university of maryland medical				4b. City, Town, or Location of Death ctr Baltimore MD	4c. County of Death Baltimore City				
5. Social Security Number n/a	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months 5	If Under 24 Hrs. Hours 5	8. Date of Birth (Month, Day, Year) 7/31/2006	9. Birthplace (State or Foreign Country) Maryland				
Usual Residence of Decedent			10a. State Delaware				10b. County Sussex		10c. City, Town or Location Laurel	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 10134 Marvel Drive			10f. Zip Code 19956				10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) n/a			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n/a				16b. Kind of Business/Industry n/a			
17. Father's Name (First, Middle, Last) Joseph Allen Waltemeyer Sr.			18. Mother's Name (First, Middle, Maiden Surname) Stephanie Lynne Tyre							
19a. Informant's Name/Relationship (Type, Print) Stephanie L. Tyre/mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10134 Marvel Dr., Laurel, DE 19956							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory				Date 8/14/06	20c. Location - City or Town, State Salisbury, MD		
21. Signature of Funeral Service Licensee Diane Thompson CFSP			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): periventricular-intraventricular hemorrhage 48 hours				Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Due to (or as a consequence of): extreme prematurity							
23d. Date of delivery Month Day Year			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. maternal cocaine use			23g. Did alcohol contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23h. Did illegal drugs contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23i. Did prescription drugs contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23j. Did other substances contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23k. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23l. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23m. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23n. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23o. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23p. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23q. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23r. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23s. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23t. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23u. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23v. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23w. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23x. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23y. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23z. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23aa. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23bb. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23cc. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23dd. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23ee. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23ff. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23gg. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23hh. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23ii. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23jj. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23kk. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23ll. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23mm. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23nn. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23oo. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23pp. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23qq. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23rr. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23ss. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23tt. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23uu. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23vv. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23ww. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23xx. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23yy. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23zz. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23aa. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23bb. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23cc. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23dd. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23ee. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23ff. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23gg. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23hh. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23kk. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23jj. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23mm. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23ll. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23oo. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23nn. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23uu. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23pp. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23qq. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23rr. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23ss. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23tt. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23yy. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23vv. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23aa. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23zz. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23bb. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23dd. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23ee. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23ff. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23gg. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23hh. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23kk. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23jj. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23mm. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23ll. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23oo. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23nn. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23uu. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23pp. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23qq. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23rr. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23ss. Did other factors contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30880  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ernest Warren Wilson, Sr.</b>								2. Date of Death Month Day Year <b>SEPTEMBER 15 2006</b>	3. Time of Death 0215 M
	4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>				4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>215-20-7117</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>01/10/1924</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Allegany</b> 10c. City, Town or Location <b>Cumberland</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number <b>11500 Precious Springs Rd, SE</b>				10f. Zip Code <b>21502</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner and Operator</b>			16b. Kind of Business/Industry <b>Auto Repair</b>		
	17. Father's Name (First, Middle, Last) <b>George Oscar Wilson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Estella Wentling</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Geraldine G. Wilson / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11500 Precious Springs Rd, SE., Cumberland, MD 21502</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Robert C. Adams</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Hermon Cemetery</b>			Date <b>09/19/2006</b>	20c. Location - City or Town, State <b>Cumberland, MD</b>			
	21. Signature of Funeral Service Licensee <b>Robert C. Adams</b>		22. Name and Address of Facility <b>Adams Family Funeral Home, P.A.</b>			<b>404 Decatur Street, Cumberland, MD 21502</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>MINUTES</b>	
	<p>a. <b>Respiratory Failure</b> Due to (or as a consequence of):</p> <p>b. <b>Subcutaneous Swelling</b> Due to (or as a consequence of):</p> <p>c. <b>Carotid Endarterectomy</b> Due to (or as a consequence of):</p> <p>d. <b>Cardiovascular Disease</b></p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D54411</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 15, 2006</b>				
	30. Name and address of person who completed cause of death (Item 2a) (Type, Print) <b>DR. BEVERLY CALKINS 500 MEMORIAL AVENUE SUITE 105 CUMBERLAND, MARYLAND 21502</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 18 2006</b>		32. Registrar's Signature <b>B. Calkins</b>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5  
T.T.  
H.R.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Amend Items 27,28a-f per

Certificate of Death

Reg. No.

2006 30881

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death			
	Lillian Walker	09 15 04	13 15 M			
Funeral Director	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
	WMHS Braddock Campus	Cumberland	Allegany			
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	8. If Under 1 Year Months Days Hours Min.	9. Date of Birth (Month, Day, Year)	10. Birthplace (State or Foreign Country)
	214-01-0349	89			03-Mar-1917	Maryland
Usual Residence of Decedent						
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Maryland	Allegany	Frostburg				
10e. Street and Number	10f. Zip Code			10g. Citizen of What Country?		
11901 Legislative Road	21532-			U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
Elementary/Secondary (0-12) 8	College (1-4 or 5+) 0	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry homemaker	
17. Father's Name (First, Middle, Last) Charles William Taylor	18. Mother's Name (First, Middle, Maiden Surname) Ellen Charlotte Walker			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Washington Street Cumberland Maryland 21532		
19a. Informant's Name/Relationship (Type, Print) Linda Buckel daughter	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park	Date	20c. Location - City or Town, State 18-Sep-2006 Frostburg Maryland		
21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death  1500 YRS 4 YEARS YEARS					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)	CERTIFICATION APPROVED BY MEDICAL EXAMINER			23d. Date of delivery Month Day Year	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Unknown	28b. Time of Injury Unknown M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	23f. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown	28d. Describe how injury occurred Multiple falls					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	28f. Location (Street and Number or Rural Route Number, City or Town, State) Unknown, MD					
29b. Signature and title of certifier 	29c. License number 018769	29d. Date signed (Month, Day, Year) 09/16/06 21502				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James M. Raven MD						
31. Date filed (Month, Day, Year) SEP 18 2006	32. Registrar's Signature 					

Baltimore, Maryland 21215-0036  
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21205-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30882  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANNA WATKINS</b>							2. Date of Death Month Day Year <b>September 11, 2006</b>	3. Time of Death <b>8:48 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>FREDERICK</b>			4c. County of Death <b>FREDERICK</b>		
Funeral Director	5. Social Security Number <b>212-74-6471</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>July 22, 1936</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>1752 Carriage Way</b>				10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: White</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Aide</b>			16b. Kind of Business/Industry <b>Medical facility</b>		
17. Father's Name (First, Middle, Last) <b>Raymond J. Lee, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Virginia Flynn</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marie Staley / Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8519 Indian Springs Rd./ Frederick, MD 21702</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Raymond Peterson</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cem.</b>		Date <b>09/15/2006</b>	20c. Location - City or Town, State <b>Frederick, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Raymond Peterson</b>					22. Name and Address of Facility <b>stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/ Frederick, MD 21702</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b>					Approximate Interval Between Onset and Death <b>months</b>				
<p>a. Due to (or as a consequence of): <b>Lung Cancer</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary Disease</b>					23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier <b>M. Tolson MD</b>				
					29c. License number <b>MD 51610</b>		29d. Date signed (Month, Day, Year) <b>9-14-06</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1475 Taylor Ave., Frederick, MD 21702</b>					31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>				
					32. Registrar's Signature <b>John B. Tolson</b>				

Baltimore, Maryland 21215-0036

Permit Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death2006 30883  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dawson Michael Weedon</b>							2. Date of Death Month Day Year <b>September 8, 2006</b>			3. Time of Death 11:50 A M	
	4a. Facility Name (If not institution, give street and number) <b>Northampton Manor Health Care Center</b>			4b. City, Town, or Location of Death <b>Frederick</b>			4c. County of Death <b>Frederick</b>					
Funeral Director	5. Social Security Number <b>219-05-4985</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>December 15, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent												
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>4527 Mountville Road</b>				10f. Zip Code <b>21703</b>				10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:  <b>1950-1952</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>			16b. Kind of Business/Industry <b>National Institute of Health</b>							
17. Father's Name (First, Middle, Last) <b>Joseph Weedon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Daisy Woods</b>				Health				
19a. Informant's Name/Relationship (Type, Print) <b>Charles Weedon - nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5689 Singletree Drive, Frederick, Maryland 21703</b>								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>St. Mary's Cemetery</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's Cemetery</b>			Date <b>9-14-2006</b>	20c. Location - City or Town, State <b>Petersville, Maryland</b>				
21. Signature of Funeral Service licensee <b>Sharon Camille Cline</b>				22. Name and Address of Facility <b>Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death)  <b>Myocardial infarction</b>												
Approximate Interval Between Onset and Death <b>minutes</b>												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
<p>a. Due to (or as a consequence of):  <b>Hypertension</b></p> <p>b. Due to (or as a consequence of):  <b>Diabetes mellitus, type two</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Diabetes mellitus, type two</b>												
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier  <b>Cecil Gessertino</b>				29c. License number <b>MD054890</b>				29d. Date signed (Month, Day, Year) <b>9/9/2006</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  <b>Caroline Gessertino 610 9th Avenue Brunswick, MD 21706</b>												
31. Date filed (Month Day Year) <b>SEP 15 2006</b>				32. Registrar's Signature  <b>Karen S. Spotts</b>								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

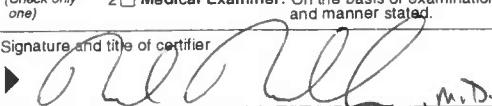
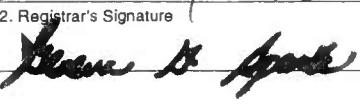
State of Maryland / Department of Health and Mental Hygiene

006 30884

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Horace F. Wilhelm, Jr.</b>						2. Date of Death Month Sept. Day 9, Year 2006		3. Time of Death 11:00 a M	
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>5917 Horn Point Rd.</b>			4b. City, Town, or Location of Death <b>Cambridge</b>			4c. County of Death <b>Dorchester</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>218-26-8653</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>June 29, 1930</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
		Usual Residence of Decedent		10a. State <b>Maryland</b> 10b. County <b>Dorchester</b> 10c. City, Town or Location <b>Cambridge</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>5917 Horn Point Rd.</b>			10f. Zip Code <b>21613</b>			10g. Citizen of What Country? <b>USA</b>			
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.		
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>			16b. Kind of Business/Industry <b>Broadcasting</b>				
		17. Father's Name (First, Middle, Last) <b>Horace F. Wilhelm, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Muriel Chalk</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>Kurt Stephen Wilhelm/Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10512 Bill Lilly Court, Laurel, MD 20723</b>						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Old Trinity Church Cem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Old Trinity Church Cem.</b>			Date <b>9/16/2006</b>			20c. Location - City or Town, State <b>Church Creek, MD</b>	
		21. Signature of Funeral Service Licensee <b>Holleen F. Wilhelm-Bromwell</b>			22. Name and Address of Facility <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613</b>						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death <b>5 minutes</b>						
		<p>a. Due to (or as a consequence of): <b>Atherosclerotic cardiovascular disease</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			26. Place of Death (Check only one)			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29b. Signature and title of certifier 			29c. License number <b>D50804</b>			29d. Date signed (Month, Day, Year) <b>9-12-06</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mark Malpus, M.D. 408 Byrn Street Cambridge, MD 21613</b>									
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 13 2006</b>		32. Registrar's Signature 							

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event.  Medical Examiner must be notified all once.

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event.  Medical Examiner must be notified all once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30885

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Lucky L. Whitman		September 7 2006				11:10 p <sup>M</sup>	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Mallard Bay Care Center		Cambridge				Dorchester	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 17, 1928	9. Birthplace (State or Foreign Country) Maryland
213-24-0934			77				
10a. State MD		10b. County Dorchester	10c. City, Town or Location Cambridge				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 520 Glenburn Ave.		10f. Zip Code 21613				10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry unknown		16c. Date of Death unknown	
17. Father's Name (First, Middle, Last) Albert J. Whitman				18. Mother's Name (First, Middle, Maiden Surname) Ethel Jane Fluehart			
19a. Informant's Name/Relationship (Type, Print) Renee Tyler p.r.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Glenburn Ave., Cambridge, MD 21613					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date	20c. Location - City or Town, State Salisbury, MD		
21. Signature of Funeral Service Licensee ► <i>Renee Tyler</i>		22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. <i>Urinary tract infection</i> Due to (or as a consequence of):</p> <p>b. <i>Chronic schizophrenia</i> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 047924					
29b. Signature and title of certifier ► <i>Norman Thaway MD</i>		29d. Date signed (Month, Day, Year) 9.8.06					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORMAN THAWAY 300 AURORA ST CAMBRIDGE MD 21613							
31. Date filed (Month, Day, Year) SEP 12 2006		32. Registrar's Signature <i>Seana D. Spaulding</i>					

ORIGINAL

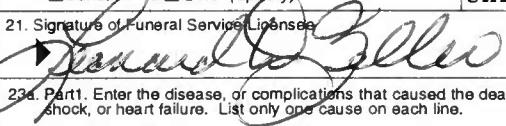
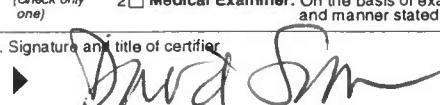
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30886

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Glen William Wilson</b>				2. Date of Death Month Day Year <b>September 7, 2006</b>	3. Time of Death 8:53 P M			
	4a. Facility Name (If not institution, give street and number) <b>400 Wrights Avenue</b>		4b. City, Town, or Location of Death <b>Hurlock</b>		4c. County of Death <b>Dorchester</b>				
Funeral Director	5. Social Security Number <b>218-24-5746</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 17, 1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Hurlock</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>400 Wrights Avenue</b>			10f. Zip Code <b>21643</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Owner/Operator</b>		16b. Kind of Business/Industry <b>Petroleum Distribution</b>				
	17. Father's Name (First, Middle, Last) <b>Glenn Gasaway Wilson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Bell</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Norma L. Wilson/Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>400 Wrights Avenue, Hurlock, Maryland 21643</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Unity Washington Cem.</b>		Date <b>9/11/2006</b>	20c. Location - City or Town, State <b>Hurlock, Maryland</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Zeller Funeral Home, P. O. Box 207, 106 Main Street, East New Market, MD 21631</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Colon cancer</b>							Approximate Interval Between Onset and Death <b>1 year 5 months</b>	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D37887</b>						
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>9/8/06</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Smith, MD 29406 Pointall Drive - Suite 5, Easton, MD 21601</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 12 2006</b>		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30887

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Elwood Lacey Wooleyhand</i>							2. Date of Death Month Day Year <i>September 15 2006 21:39 M</i>	3. Time of Death		
	4a. Facility Name (If not institution, give street and number) <i>Memorial Hospital</i>			4b. City, Town, or Location of Death <i>Easton</i>			4c. County of Death <i>Talbot</i>				
Funeral Director	5. Social Security Number <i>213-24-2373</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78</i>	Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>September 7, 1928</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	10a. State <i>Maryland</i>		10b. County <i>Caroline</i>		10c. City, Town or Location <i>Denton</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <i>509 Market Street</i>				10f. Zip Code <i>21629</i>			10g. Citizen of What Country? <i>United States of America</i>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Caucasian</i>			14. Race - American Indian, Black, White, etc. Specify: <i>Caucasian</i>			
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 9</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Electrician</i>			16b. Kind of Business/Industry <i>Manufacturing nylon production</i>						
17. Father's Name (First, Middle, Last) <i>Otis Henry Wooleyhand</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Florence Elizabeth Ross</i>							
19a. Informant's Name/Relationship (Type, Print) <i>Dorothy M. Wooleyhand Wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>509 Market Street, Denton, Maryland 21629</i>			Date <i>9/19/2006</i>		20c. Location - City or Town, State <i>Denton, Maryland</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Ranley P. Moore</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Denton Cemetery</i>			22. Name and Address of Facility <i>Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629</i>						
21. Signature of Funeral Service Licensee <i>Ranley P. Moore</i>											
23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>9 Unknown</i>			23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown <i>Hypertension hypertrophic heart</i>											
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>Yes</i>		23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>No</i>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <i>Ignatius L. D. Nardo, M.D.</i>		29c. License number <i>D31542</i>			29d. Date signed (Month, Day, Year) <i>September 16, 2006</i>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Ignatius L. D. Nardo, M.D. / Easton Memorial Hospital</i>											
31. Date filed (Month, Day, Year) <i>SEP 18 2006</i>		32. Registrar's Signature <i>John S. Jones</i>									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend Items 14,23a,PtII per Dr/FH,G859, 09/28/06dnb  
Certificate of Death

2006 30888

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LARRY WILLIAMS</b>							2. Date of Death Month <b>09</b> Day <b>14</b> Year <b>2006</b>	3. Time of Death <b>13:15</b>
	4a. Facility Name (If not institution, give street and number) <b>Metro Transition Center Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore, MD</b>			4c. County of Death <b>Baltimore city</b>	
Funeral Director	5. Social Security Number <b>900-29-5435</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>41 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>12/16/64</b>	9. Birthplace (State or Foreign Country) <b>Delaware</b>	
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Talbot</b> 10c. City, Town or Location <b>Easton</b> 10d. Inside City Limits <b>1 Yes 2 No</b>								
To Be Completed by Funeral Director	10e. Street and Number <b>21 S. Hanson St. Apt. 2</b>				10f. Zip Code <b>21601</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 Yes 2 No</b> Specify:			14. Race - American Indian, Black, White, etc. <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Landscaper</b>		16b. Kind of Business/Industry <b>Holiday Landscaping</b>				
	17. Father's Name (First, Middle, Last) <b>Floyd Henry Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lenora Frances Williams</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Rosemary Williams, Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 1642 Easton, MD 21601</b>						
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Federal Hill Cemetery</b>			Date <b>9/23/2006</b>	20c. Location - City or Town, State <b>Federalsburg, MD</b>		
	21. Signature of Funeral Service Licensee <b>Jammie Y. Shaw</b>		22. Name and Address of Facility <b>Bennie Smith Funeral Home Easton, MD 21601 426 Dover Rd.</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Advanced malignant melanoma.</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____								Approximate Interval Between Onset and Death <b>5mths.</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify) Infirmary.</b>		24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>		
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day Year) <b>5 Pending investigation</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>954 Forrest St., Baltimore, MD 20912</b>				
	29a. Certifier (Check only one) <b>1 Certifying Physician 2 Medical Examiner</b>		29b. Signature and title of certifier <b>Bishaw M.D.</b> 29c. License number <b>D0063631</b> 29d. Date signed (Month, Day, Year) <b>09/14/06</b>						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HIRUY BISHAW</b>						
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 28 2006</b>		32. Registrar's Signature <b>Hiruy B. Bishaw</b>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30889

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f below  
any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year			3. Time of Death			
<i>Curtis Benjamin Young</i>		Sept 2 2006			10:35A M			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death			
<i>514 High Street</i>		<i>Cambridge</i>			<i>Dorchester</i>			
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>64</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) <i>Sept 20, 1941</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
Usual Residence of Decedent							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State	10b. County	10c. City, Town or Location					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<i>MD</i>	<i>Dorchester</i>	<i>Cambridge</i>						
10e. Street and Number	10f. Zip Code					10g. Citizen of What Country?		
<i>514-High Street</i>	<i>21613</i>					<i>USA</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1967</i> <i>1973</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
15. Decedent's Education (Specify only highest grade completed) <i>12</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Corrections Officer</i>	16b. Kind of Business/Industry <i>County Corrections</i>						
17. Father's Name (First, Middle, Last) <i>Henry Wilmer Young</i>	18. Mother's Name (First, Middle, Maiden Surname) <i>Virginia Thomas</i>							
19a. Informant's Name - Relationship (Type, Print) <i>Melvin Henry Young</i>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>806 - High Street Cambridge, MD. 21613</i>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Veteran's Cemetery</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>HENRY FUNERAL HOME, P. A.</i>	Date <i>9/8/06</i>					20c. Location - City or Town, State <i>Hurlock, MD.</i>	
21. Signature of Funeral Service Licensee <i>Janelle C. Henry</i>	22. Name and Address of Facility <i>510 Washington St. Cambridge, MD. 21613</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Myocardial Infarct</i>						Approximate Interval Between Onset and Death <i>YES</i>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): <i>Sabotis</i> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year) <i>9-7-06</i>	
29b. Signature and title of certifier <i>Mary Ann D. Moore, M.D.</i>	29c. License number <i>P31766</i>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mary Ann D. Moore, M.D. 300 Dorchester Ave. Cambridge</i>								
31. Date filed (Month, Day, Year) <i>SEP 07 2006</i>	32. Registrar's Signature <i>Laura B. Jones</i>							

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

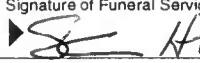
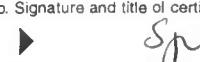
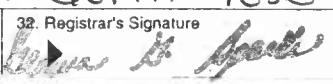
State of Maryland / Department of Health and Mental Hygiene

2006 30890

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Michele Ashburn</b>							2. Date of Death Month <b>SEPT</b> Day <b>25</b> Year <b>2006</b>	3. Time of Death <b>12-05A M</b>		
	4a. Facility Name (If not institution, give street and number) <b>Genesis Brightwood Center</b>				4b. City, Town, or Location of Death <b>Lutherville</b>			4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>212-62-6906</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>53</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>08/05/1953</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Baltimore City</b> 10c. City, Town or Location <b>Baltimore</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>19 Glider Drive</b>				10f. Zip Code <b>21206</b>			10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Manager</b>			16b. Kind of Business/Industry <b>Pharmacy/Retail</b>					
	17. Father's Name (First, Middle, Last) <b>William Edmonds Richards</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Margaret Partridge</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Shane Ashburn/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>105 Lyndale Avenue Nottingham, MD 21236</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory Inc. 2006</b>			Date <b>Sep 29</b>	20c. Location - City or Town, State <b>Beltsville, Maryland</b>			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Cremation and Funeral Alternatives</b> <b>8717 Green Pastures Drive Baltimore, Maryland 21286</b>						
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 day</b>		
	<p>a. <b>C O I Bleeding</b> Due to (or as a consequence of):</p> <p>b. <b>C IRRHOSIS OF LIVER</b> Due to (or as a consequence of):</p> <p>c. <b>M RSA BACTERIUM A</b> Due to (or as a consequence of):</p> <p>d.</p>								<b>months</b>		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 								29c. License number <b>D0053150</b>	29d. Date signed (Month, Day, Year) <b>SEPT 25TH 2006</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHALOMA ALA GUPTA 9650 SANTIAGO RD SUITE 110 B1045</b>										
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>				32. Registrar's Signature 						

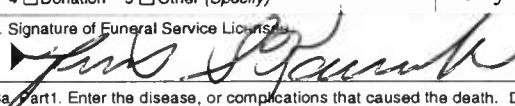
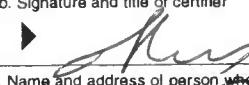
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30891

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN E. APPOLD SR.</b>					2. Date of Death Month Day Year <b>Sept. 28, 2006</b>	3. Time of Death <b>8:50 a M</b>
	4a. Facility Name (If not institution, give street and number) <b>2206 Eagle Street</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-32-8130</b>		6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (in yrs. last birthday) <b>71 Yrs.</b>	If Under 1 Year Months Days Hours Min. <b> </b>	8. Date of Birth (Month, Day, Year) <b>May 31, 1935</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
To Be Completed by Funeral Director	10e. Street and Number <b>2206 Eagle Street</b>			10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 0 Assembly Line Worker</b>			16b. Kind of Business/Industry <b>General Motors Corp.</b>	
17. Father's Name (First, Middle, Last) <b>Harry W. Appold</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie J. Miller</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Tammy Appold (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2206 Eagle Street, Baltimore, Maryland 21223</b>			
20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>		Date <b>10-02-06</b>	20c. Location - City or Town, State <b>Brooklyn Park, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CARCINOMA</b> Approximate Interval Between Onset and Death <b>3 months</b>							
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  IF FEMALE: 23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>							
23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>							
24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>				24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>			
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day Year) <b> </b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred <b> </b>		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b> </b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b> </b>					
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>019640</b>		29d. Date signed (Month, Day, Year) <b>9/28/06</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marc S. Posner M.D. 1147 S. Hanover St. Baltimore Md. 21230</b>				31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>			
32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

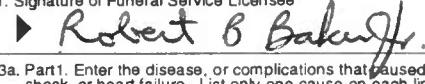
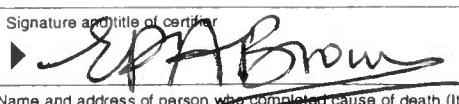
State of Maryland / Department of Health and Mental Hygiene

2006 30892

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Audree Smith Alexander</b>				2. Date of Death Month Day Year <b>September 27, 2006 6:07 P M</b>		3. Time of Death			
	4a. Facility Name (If not institution, give street and number) <b>2105 Belfry Lane</b>		4b. City, Town, or Location of Death <b>Mitchellville</b>			4c. County of Death <b>Prince Georges</b>				
Funeral Director	5. Social Security Number <b>230-18-1857</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug. 19, 1922</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>			
	Usual Residence of Decedent <b>Prince Georges</b>		10c. City, Town or Location <b>Mitchellville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number <b>2105 Belfry Lane</b>			10f. Zip Code <b>20721</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4</b> <b>Claims Examiner</b>			16b. Kind of Business/Industry <b>U.S. Govt.</b>				
	17. Father's Name (First, Middle, Last) <b>Timothy L. Smith</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Estelle Ammons</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Robert M. Alexander-Husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2105 Belfry Lane Mitchellville, Md. 20721</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Quantico National Cemetery</b>		Date <b>10/6/06</b>	20c. Location - City or Town, State <b>Triangle, Va.</b>				
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Chinn Funeral Service 2605 S. Shirlington Rd. Arlington, Va. 22206</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death		
	<p>a. <b>Advanced Senile Dementia</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Osteoporosis, Sacral Decubitus Ulcer</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D0053941</b>						29d. Date signed (Month, Day, Year) <b>9/28/06</b>	
	29b. Signature and title of certifier 									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Emmanuel Brown 4302 St Barnabas Road Suite B Temple Hills, Md. 20748</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30893

Reg. No.

1-  
For  
State  
Registrar

Physician  
/Medical  
Examiner

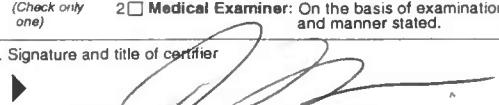
Funeral  
Director

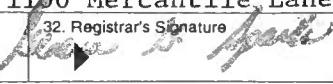
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) <b>THOMAS A. ALSTON</b>							2. Date of Death Month <b>9</b> Day <b>19</b> Year <b>06</b>	3. Time of Death <b>5:46 PM</b>
4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital</b>				4b. City, Town, or Location of Death <b>Cheverly, MD</b>			4c. County of Death <b>P.G.</b>	
5. Social Security Number <b>237-66-9019</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>12/10/43</b>	9. Birthplace (State or Foreign Country) <b>Chapel Hill, NC</b>	
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>P.G.</b> 10c. City, Town or Location <b>Largo</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number <b>100012 Cedar Hollow Lane</b>				10f. Zip Code <b>20876</b>			10g. Citizen of What Country? <b>US</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Marketing Representative</b>			16b. Kind of Business/Industry <b>Private Industry</b>	
17. Father's Name (First, Middle, Last) <b>Thomas A. Alston, II</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Weaver</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Yvonne R. Alston/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>100012 Cedar Hollow Lane, Largo, MD 20876</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chapel Hill Memorial</b>			Date <b>9/25/06</b>	20c. Location - City or Town, State <b>Chapel, N.C.</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Frazier's Funeral Home, Inc.</b> <b>389 Rhode Island Avenue, N.W., Wash., DC 20001</b>				

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		Approximate Interval Between Onset and Death	
<b>a.</b> <i>Coronary artery disease</i> Due to (or as a consequence of): <b>b.</b> <i>Essential hypertension</i> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>									
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23g. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number <b>D31069</b>		29d. Date signed (Month, Day, Year) <b>9/22/06</b>					

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GEORGE BONE, MD</b>		31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature 	
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

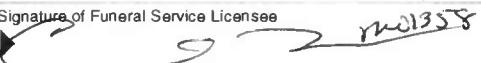
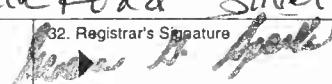
State of Maryland / Department of Health and Mental Hygiene

2006 30894

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

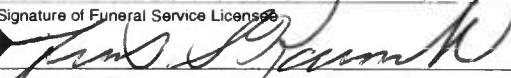
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SUSAN BIENIASZ</b>							2. Date of Death Month <b>9</b> Day <b>23</b> Year <b>06</b>	3. Time of Death <b>9:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Renaissance Gardens</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>168-28-1071</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>05/30/1933</b>	9. Birthplace (State or Foreign Country) <b>PA</b>				
To Be Completed by Funeral Director	10a. State <b>MD</b>				10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3128 Gracefield Rd. T-4</b>				10f. Zip Code <b>20904-</b>			10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>4</b>		16b. Kind of Business/Industry <b>Education</b>						
	17. Father's Name (First, Middle, Last) <b>Charles Bentel</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Bucklen</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Joel Bieniasz/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>806 1/2 5th St. #1 Laurel, MD 20707-</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory Inc. 2006</b>		Date <b>Sep 27</b>	20c. Location - City or Town, State <b>Beltsville, Maryland</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rapp Funeral &amp; Cremation Services</b> <b>933 Gist Ave. Silver Spring, Maryland 20910-</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
	<p>a. <i>Lung carcinoma with metastatic brain disease</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D0043375</b>			29d. Date signed (Month, Day, Year) <b>9/25/06</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>3128 Gracefield Road Silver Spring, MD 20904</b>		32. Registrar's Signature 								
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>										

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State of Maryland / Department of Health and Mental Hygiene 2006 30895  
Amend item#11, per FH, G859, 9/29/06 TT Certificate of Death

1- For State Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES J BEAL</b>				2. Date of Death Month <b>SEPTEMBER</b> Day <b>27</b> Year <b>2006</b>		3. Time of Death <b>2:55 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BALTIMORE WASHINGTON MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>GLEN BURDIE</b>		4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>215-30-2375</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Feb. 10, 1933</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Pasadena</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>8361 Country Life Road</b>			10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouseman			16b. Kind of Business/Industry <b>Grocery Warehouse</b>		
	17. Father's Name (First, Middle, Last) <b>Charles M. Beal</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude M. Rittmyer</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Darlene M. Cole (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7901 Royal Mint Place, Pasadena, Maryland 21122</b>			
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Park</b>		Date <b>09-30-06</b>	20c. Location - City or Town, State <b>Elkridge, Maryland</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Metabolic Acidosis</b>						Approximate Interval Between Onset and Death <b>Hours</b>	
	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Renal Failure</b>						Approximate Interval Between Onset and Death <b>Days</b>	
	c. <b>Acute Myocardial infarction</b>						Approximate Interval Between Onset and Death <b>Days</b>	
	d.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hydrocephalus, Cardiogenic shock</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number <b>DOO32744</b>			29d. Date signed (Month, Day, Year) <b>September 27 2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Maria Covitria MD</b>		31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>			32. Registrar's Signature 		

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

Reg. No. 2006 30896

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Harry Douglas Barney</b>						2. Date of Death Month Day Year <b>SEP 26, 2006</b>	3. Time of Death <b>3:20p M</b>		
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>20 Westmoreland Street</b>			4b. City, Town, or Location of Death <b>Westminster</b>			4c. County of Death <b>Carroll</b>			
To Be Completed by Funeral Director		5. Social Security Number <b>235-68-9143</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV 7, 1945</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		
		Usual Residence of Decedent		10a. State <b>Maryland</b> 10b. County <b>Carroll</b> 10c. City, Town or Location <b>Westminster</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>20 Westmoreland Street</b>			10f. Zip Code <b>21157</b>			10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>2 CPA/Business Owner</b>		16b. Kind of Business/Industry <b>Accounting</b>					
		17. Father's Name (First, Middle, Last) <b>Emil Franklin Barney</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Esther Unger</b>						
		19a. Informant's Name/Relationship (Type, Print) <b>Jill Barney - wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20 Westmoreland Street Westminster, MD 21157</b>							
		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>All County Cremation</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>9/30/2006</b>	20c. Location - City or Town, State <b>Sykesville, MD</b>				
		21. Signature of Funeral Service Licensee <b>Dawn McDonald MOB348</b>		22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, MD 21784 (410-795-1400)</b>							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
		<p>a. <i>Acute myocardial infarction</i> Due to (or as a consequence of):</p> <p>b. <i>Hypertension</i> Due to (or as a consequence of):</p> <p>c. <i>Diabetes Mellitus</i> Due to (or as a consequence of):</p> <p>d. <i>Hyperlipidemia</i>.</p>									
		IF FEMALE: <b>NA</b>		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29b. Signature and title of certifier <b>Sureja MD</b>		29c. License number <b>D22663</b>			29d. Date signed (Month, Day, Year) <b>9-27-06</b>				
		30. Name and address of person who completed cause of death (Item 2a) (Type, Print) <b>Murat J Sureja MD, 4212 Little Rd, Westminster Md. 21771</b>									
		31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature <b>Leanne B. Hayes</b>							

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

ence.

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
registrar

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1- For Amend Item 25 per dr., 0859, 09/29/00dhb State of Maryland / Department of Health and Mental Hygiene  
State Registrar Certificate of Death 2006 30897  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM FRANK BOWERS</b>							2. Date of Death Month <b>09</b>	Day <b>25</b>	Year <b>2006</b>	3. Time of Death <b>9:24 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>BALTIMORE VA MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>NIA</b>				
Funeral Director	5. Social Security Number <b>218-07-9497</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug. 13, 1917</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number <b>410 South Vincent Street</b>			10f. Zip Code <b>21223</b>			10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b>	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Freight Truck Driver</b>			16b. Kind of Business/Industry <b>Transportation</b>					
	17. Father's Name (First, Middle, Last) <b>William Frank Bowers, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha Unknown</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Bowers - Spouse</b>										
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>410 South Vincent Street, Baltimore, MD 21223</b>										
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> 1 Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Lorraine Park Cemetery</b>			20b. Place of Disposition (Name of cemetery, crematory or other place)	Date <b>9-30-2006</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>					
	21. Signature of Funeral Service Licensee <b>Catherine N. Bowers</b>										
	22. Name and Address of Facility <b>Ambrose Funeral Home, Inc.</b> <b>1328 Sulphur Spring Rd., Arbutus, MD 21227</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>MYOCARDIAL INFARCTION</b>										Approximate Interval Between Onset and Death <b>MINUTES</b>
	<p>a. Due to (or as a consequence of): <b>MYOCARDIAL INFARCTION</b></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>										
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>LUNG CANCER</b>										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown										23d. Date of delivery Month Day Year
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>										28d. Describe how injury occurred <b>By fall</b>
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>BALTIMORE VAMC 10 N. GREENE ST., BALTIMORE MD 21201</b>
	29b. Signature and title of certifier <b>Conrad May</b>										29c. License number <b>D 32186</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BALTIMORE VAMC 10 N. GREENE ST., BALTIMORE MD 21201</b>										29d. Date signed (Month, Day, Year) <b>SEPTEMBER 25, 2006</b>
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>										32. Registrar's Signature <b>Conrad May</b>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30898  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frances Hughes Bearden</b>							2. Date of Death Month Day Year <b>September 27, 2006</b>	3. Time of Death <b>10:15 A M</b>
	4a. Facility Name (If not institution, give street and number) <b>8820 Walther Blvd. "Apt. 2007"</b>			4b. City, Town, or Location of Death <b>Parkville</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>250 18 2112</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Nov. 23, 1919</b>	9. Birthplace (State or Foreign Country) <b>South Carolina</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>8820 Walther Blvd. "Apt. 2007"</b>			10f. Zip Code <b>21234</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Secretary</b>			16b. Kind of Business/Industry <b>Baltimore County Schools</b>		
	17. Father's Name (First, Middle, Last) <b>Marlowe Hughes</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Hopkins</b>						
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Robert H. Bearden III (Son)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1020 Erwin Drive Joppa, Maryland 21085</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Mountain View Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mountain View Cemetery</b>			Date <b>10/5/2006</b>	20c. Location - City or Town, State <b>Greer</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Diffuse large B cell lymphoma</b>		Approximate Interval Between Onset and Death <b>months</b>						
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): <b>a. Diffuse large B cell lymphoma</b>						
	{		b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HTN</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) <b>Hospital</b>
	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 		29c. License number <b>DJ 3115</b>		29d. Date signed (Month, Day, Year) <b>September 28th 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeff Landman 8800 Walther Blv Parkville MD 21234</b>								
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

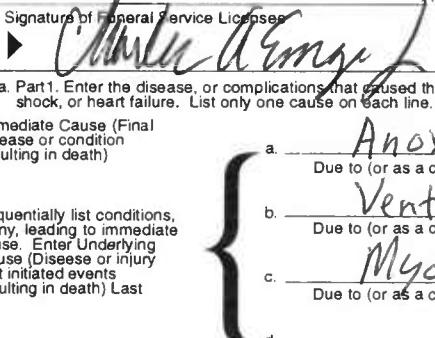
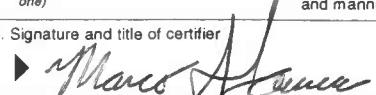
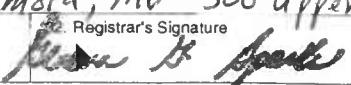
State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30899  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ethel Sparks Bradley</b>							2. Date of Death Month Day Year <b>September 25, 2006</b>	3. Time of Death M <b>22:19</b>
	4a. Facility Name (If not institution, give street and number) <b>Upper Chesapeake Medical Center</b>				4b. City, Town, or Location of Death <b>Bel Air</b>			4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>213-30-0676</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
	Usual Residence of Decedent <b>Maryland Harford</b>		10a. State <b>Maryland</b>			10b. County <b>Harford</b>			10c. City, Town or Location <b>Bel Air</b>
10e. Street and Number <b>602 Churchill Road Unit B</b>		10f. Zip Code <b>21014</b>			10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>2</b> <b>Nurse</b>		16b. Kind of Business/Industry <b>Health Care</b>					
17. Father's Name (First, Middle, Last) <b>Frank Pierce Sparks</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ena Nevada Walton</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Robert Bradley, Jr., Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 S. Atwood Road, Bel Air, MD 21014</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Hilltop Service Corp. 9-28-06</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp. 9-28-06</b>			20c. Location - City or Town, State <b>Towson, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McComas Funeral Home, P.A.</b> <b>1317 Cokesbury Road, Abingdon, Maryland 21009</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Anoxic Encephalopathy</b>									Approximate Interval Between Onset and Death <b>1 day</b>
b. Due to (or as a consequence of): <b>Ventricular Fibrillation</b>									
c. Due to (or as a consequence of): <b>Myocardial Infarction</b>									
d.									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D40819</b>					
29b. Signature and title of certifier 				29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marco Zamora, MD 500 Upper Chesapeake Drive, Bel Air, Maryland 21014</b>									
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>				32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30900  
Certificate of Death Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM BRADFORD BANKS</b>							2. Date of Death Month Day Year <b>September 27, 2006</b>			3. Time of Death <b>5:00AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>BROADMEAD</b>			4b. City, Town, or Location of Death <b>Cockeysville</b>				4c. County of Death <b>Baltimore County</b>					
Funeral Director	5. Social Security Number <b>215-01-3285</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>98 Yrs.</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 29, 1908</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>					
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore County</b> 10c. City, Town or Location <b>Cockeysville</b>										10d. Inside City Limits <b>1 Yes 2 No</b>		
To Be Completed by Funeral Director	10e. Street and Number <b>13801 York Road</b>				10f. Zip Code <b>21030</b>			10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 Yes 2 No</b> Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sr. Executive</b>			16b. Kind of Business/Industry <b>Printing</b>						
	College (1-4 or 5+) <b>4</b>												
	17. Father's Name (First, Middle, Last) <b>George Edwin Banks</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marietta Myer</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Rebecca B. Mowbray</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7714 Ruxwood Road, Towson, Maryland 21204</b>								
Physician /Medical Examiner	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>			Date <b>9/28/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>						
	21. Signature of Funeral Service Licensee <b>Martin D. Lawson</b>		22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212</b>										
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>Bowel Obstruction</b>										Approximate Interval Between Onset and Death <b>1 week</b>		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>												
	23b. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown</b>			23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure Lumbar stenosis Atrial Fibrillation</b>										23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>			27. Manner of Death <b>1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>				28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>13801 York Rd., Cockeysville, MD</b>				29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29b. Signature and title of certifier <b>Barbara Carroll, M.D.</b>		29c. License number <b>D38392</b>	29d. Date signed (Month, Day, Year) <b>9/27/2006</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BARBARA CARROLL, M.D., 13801 York Rd., Cockeysville, MD</b>												
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature <b>Barbara Carroll</b>										

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director - After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 908-273-5056.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
1 - For State Registrar Amend item #23e, per MD G860, 10/6/06 TT Certificate of Death 2006 30901  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wendell Herl Bailey						2. Date of Death Month Day Year September 26, 2006	3. Time of Death 9:08 AM				
	4a. Facility Name (If not institution, give street and number) 1305 Swan Harbour Rd.			4b. City, Town, or Location of Death Fort Washington			4c. County of Death Prince Georges					
Funeral Director	5. Social Security Number 578-60-0472	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) September 9, 1946	9. Birthplace (State or Foreign Country) Kentucky			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland								10b. County Prince Georges	10c. City, Town or Location Fort Washington	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1305 Swan Harbour Rd.			10f. Zip Code 20744			10g. Citizen of What Country? United States					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		Technology consultant			16b. Kind of Business/Industry Cable and Telecommunications				
	17. Father's Name (First, Middle, Last) Wendell Herl Bailey				18. Mother's Name (First, Middle, Maiden Surname) Mary Alberta Benningfield							
	19a. Informant's Name/Relationship (Type, Print) Denise Bailey/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Swan Harbour Rd. Fort Washington, MD 20744							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount crematory			Date Sept. 28, 2006	20c. Location - City or Town, State Baltimore, Maryland					
	21. Signature of Funeral Service Licensee ► John O. Mitchell IV		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Head & Neck Cancer 6 Months			
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>{ a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____</p> <p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____</p>								23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier ► Gurasharma			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAYA SHARMA, MD. 1400 Forest Glen Rd #435 Silver Spring, MD 20910								29c. License number D0041119		29d. Date signed (Month, Day, Year) 09, 26, 2006	
	31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature Loren B. Bailey									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

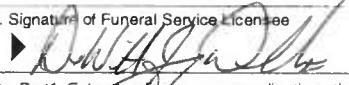
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30902

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death	
	Louis Joseph Castagneto							Month Day Year September 22, 2006			3. Time of Death 10:22 AM	
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death			
	Laurel Regional Hospital				Laurel				Prince George			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		
577-12-7171		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	86 Yrs.	Months	Days	Hours	Min.	June 6, 1919		Washington, DC		
Usual Residence of Decedent												
10a. State	10b. County		10c. City, Town or Location								10d. Inside City Limits	
MD	Anne Arundel		Laurel								<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?				
3501 Wines Lane				20724				U.S.A.				
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: White			
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			If Yes, Give Year or Dates:									
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry				
Elementary/Secondary (0-12)		College (1-4 or 5+)		Yardman				Railroad				
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)								
Regina Vetter /friend				unknown				unknown				
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Regina Vetter /friend			3501 Wines Lane, Laurel, Maryland 20724									
20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State			Ivy Hill Cemetery			Sep 27, 06			Laurel, Maryland			
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			M00773									
21. Signature of Funeral Service Licensee			22. Name and Address of Facility									
			Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389									
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Approximate Interval Between Onset and Death												
Immediate Cause (Final disease or condition resulting in death)			<p>a. <u>Aspiration</u> Due to (or as a consequence of):</p> <p>b. <u>Reflux esophagitis</u> Due to (or as a consequence of):</p> <p>c. <u>Coronary artery disease</u> Due to (or as a consequence of):</p> <p>d.</p>									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
Chronic obstructive lung disease												
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)									
29b. Signature and title of certifier 			29c. License number D17638									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			29d. Date signed (Month, Day, Year) 9/22/06									
T. J. Orellano, M.D. 7350 Van Dusen Road, #340, Laurel, Maryland 20707												
31. Date filed (Month, Day, Year) SEP 29 2006			32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department. If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30903

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  Adam William Capps							2. Date of Death Month Sep. Day 19 Year 2006		3. Time of Death 1724 M
	4a. Facility Name (If not institution, give street and number)  Union Memorial Hospital			4b. City, Town, or Location of Death  Baltimore City			4c. County of Death  N/A			
Funeral Director	5. Social Security Number 215-04-3718	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 23 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 4, 1983	9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent  10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Dundalk 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
10e. Street and Number  1642 Gray Place				10f. Zip Code  21222			10g. Citizen of What Country?  United States			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Mechanic		16b. Kind of Business/Industry Dap Inc.						
17. Father's Name (First, Middle, Last)  Michael A. Baublitz				18. Mother's Name (First, Middle, Maiden Surname)  Christine L. Capps						
19a. Informant's Name/Relationship (Type, Print)  Christine L. Capps (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1602 Melbourne Road Apt. A Dundalk, MD 21222						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)  Hilltop Service Corp.			Date 9/27/2006		20c. Location - City or Town, State Towson, Maryland			
21. Signature & Funeral Service License  <i>[Signature]</i>										
22. Name and Address of Facility  Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  <i>Malignant HyperThermia</i> Approximate Interval Between Onset and Death 1Y2M										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <i>General Anesthesia</i>										
a. Due to (or as a consequence of):  <i>Malignant HyperThermia</i>		b. Due to (or as a consequence of):  <i>General Anesthesia</i>		c. Due to (or as a consequence of):  <i>Malignant HyperThermia</i>		d.  <i>Malignant HyperThermia</i>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  <i>Hospital</i>										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)  <i>9/19/2006</i>		28b. Time of Injury  <i>Unknown</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred  <i>Subject became hyperthermic during anesthesia</i>		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  <i>Hospital</i>										
28f. Location (Street and Number or Rural Route Number, City or Town, State)  <i>201 E. University Parkway, Baltimore MD</i>										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  <i>Keith A. Segraman MD</i>										
29c. License number  <i>D43247</i>										
29d. Date signed (Month, Day, Year)  <i>9/22/06 2006</i>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  <i>Keith A. Segraman MD 1400 Front Ave Lothianville MD</i>										
31. Date filed (Month, Day, Year)  <i>SEP 29 2006</i>										
32. Registrar's Signature  <i>[Signature]</i>										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, WJ

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30904

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death
	SHARON COSTELLO							SEPTEMBER 25 2006			1539 PM
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death			
	NORTHWEST HOSPITAL				RANDALLSTOWN			BALTIMORE			
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month Day Year)		9. Birthplace (State or Foreign Country)		
	214-40-0746		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	64 Yrs.	Months	Days	Hours	Min.	04/28/1942 MD		
Usual Residence of Decedent											
10a. State	10b. County		10c. City, Town or Location								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
MD	N/A		BALTIMORE								
10e. Street and Number					10f. Zip Code				10g. Citizen of What Country?		
7013 FIELDCREST ROAD					21215				USA		
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry					
Elementary/Secondary (0-12) 12			College (1-4 or 5+) HOUSEWIFE			OWN HOME					
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)						
JACK FRIEDMAN NETTIE FINE											
19a. Informant's Name/Relationship (Type, Print)											
PHYLLIS SCHUSSLER / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
4228 ARTERS MILL ROAD - WESTMINSTER, MD 21158											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State		
			BNAI ISRAEL CEMETERY			09/27/2006			BALTIMORE, MD		
21. Signature of Funeral Service Licensee ► Jay O'Leary											
22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.											
Immediate Cause (Final disease or condition resulting in death)											
23b. Part II. Enter underlying cause. Enter <u>Underlying Cause</u> (Disease or injury that initiated events resulting in death) Last											
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown											
23d. Date of delivery Month Day Year											
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Did the decedent have any significant conditions contributing to death but not resulting in the underlying cause given in Part I? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide											
28a. Date of Injury (Month, Day Year)			28b. Time of Injury			28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier ► Debrah Watson, MD											
29c. License number D0059736											
29d. Date signed (Month, Day, Year) September 25, 2006											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
DEBORA WATSON, MD. NORTHWEST HOSPITAL 5401 OLD COURT ROAD											
31. Date filed (Month, Day, Year) SEP 29 2006											
32. Registrar's Signature Debrah A. Watson											

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or if Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

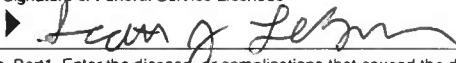
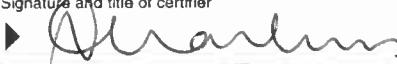
State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 006 30905

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William B. Duncan							2. Date of Death Month Day Year September 26, 2006	3. Time of Death 10:15 PM			
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore County				
Funeral Director	5. Social Security Number 456-05-5532		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 3, 1920	9. Birthplace (State or Foreign Country) Texas				
	Usual Residence of Decedent 10a. State Maryland		10b. County Baltimore County		10c. City, Town or Location Timonium			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 3 Kilglass Court Apt. 104				10f. Zip Code 21093			10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry Attorney							
	17. Father's Name (First, Middle, Last) Robert John Duncan				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Banks							
	19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret B. Duncan (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Kilglass Court Apt. 104, Timonium, Maryland 21093									
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel		Date Sept. 28, 2006	20c. Location - City or Town, State Forest Hill, Maryland						
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr. P.A. 2325 York Road, Timonium Maryland 21093									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. PROSTATE CANCER Due to (or as a consequence of):		Approximate Interval Between Onset and Death years							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier 		29c. License number D 58307		29d. Date signed (Month, Day, Year) September 27 2006							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aaron Cunkum 555 W. Towson Run Blvd Towson MD 21204											
	31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #8, PER PH. G860, 10/10/06, MS

State of Maryland / Department of Health and Mental Hygiene

2006 30906

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department: If item 27 is marked other than "natural", or items 23a-f show  
any injury or other traumatic event. The Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1- For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Bernard Henry Denis, Jr.

2. Date of Death  
Month Day Year  
September 26, 2006 12:18 AM

4a. Facility Name (If not institution, give street and number)

1037 Cooks Lane

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Maryland

5. Social Security Number

219-44-5254

6. Sex

M  F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

Oct. 3, 1966

9. Birthplace (State or Foreign  
Country)

Maryland

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes  No

10e. Street and Number

1037 Cooks Lane

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

Never Married  Married  
 Widowed  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes  No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes  No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Business Owner

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Bernard Henry Denis

18. Mother's Name (First, Middle, Maiden Surname)

Eunice Bossom

19a. Informant's Name/Relationship (Type, Print)

Danielle C. Duerling-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3506 Greenvale Road; Baltimore, MD 21229

20a. Method of Disposition

Burial  Cremation  Removal from State  
 Donation  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

9/27/2006

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Sterling Ashton Schwab Witzke  
Funeral Home of Catonsville, Inc.  
1630 Edmondson Avenue; Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)

Small Cell Lung Cancer

Approximate Interval Between Onset and Death  
10 mo.

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
 Yes  No  
 Unknown

23c. If yes, outcome of pregnancy  
 Live birth  Fetal death  Ectopic pregnancy  
 Pregnant at time of death  Other (Specify)  
 Unknown

23d. Date of delivery  
Month Day Year

25. Was case referred to medical examiner?

Yes  No

26. Place of Death (Check only one)

Hospital:  Inpatient  ER/Outpatient  DOA Other:  Nursing Home  Residence  Other (Specify)

27. Manner of Death

Natural  Pending investigation  
 Accident  Could not be determined  
 Suicide  Determined  
 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

Yes  No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
22 S. Greene St N9E08 Baltimore MD 21201

Martin J. Edelman, M.D.

31. Date filed (Month, Day, Year)

SEP 29 2006

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30907  
Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death		
Wade H Donnelly		Sept 27 2006				1:15 AM		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death		
University of Maryland Medical CTR		Baltimore				Baltimore		
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sept, 18, 1927	9. Birthplace (State or Foreign Country) Maryland	
6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.						
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 716 Stamford Road				10f. Zip Code 21229			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-51		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef		16b. Kind of Business/Industry Hyatt Regency Corp.				
17. Father's Name (First, Middle, Last) Russell J. Donnelly		18. Mother's Name (First, Middle, Maiden Surname) Margaret Litzau						
19a. Informant's Name/Relationship (Type, Print) Dolores M. Donnelly Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Stamford Road; Baltimore, MD 21229						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Immanuel Lutheran Cem.		Date 9/30/2006			20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 6 days				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. pneumonia Due to (or as a consequence of):						
		b. chronic obstructive pulmonary disease Due to (or as a consequence of):					7 10 years	
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ischemic congestive heart failure, pulmonary hypertension, tonsillar cancer s/p radiation, dementia				23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number AU 4176435 H17418		29d. Date signed (Month, Day, Year) Sept 27, 2006				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sara M. Handy, 22 South Greene St, Baltimore, MD 21201								
31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30908

Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year				3. Time of Death	
<i>Odelle H. Dutton</i>				<i>SEPT 25 2006</i>				1505 PM	
4a. Facility Name (If not institution, give street and number) <i>4105 Glenmore Ave - Assisted Living</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>N/A</i>	
5. Social Security Number <i>214 16 5016</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>92</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <i>May 11, 1914</i>	9. Birthplace (State or Foreign Country) <i>Virginia</i>		
Usual Residence of Decedent <i>Holiday Baltimore</i>				10c. City, Town or Location <i>Woodlawn</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>1814 New Castle Road</i>				10f. Zip Code <i>21244</i>				10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>4 years</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>				14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4 years</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Registered Nurse</i>				16b. Kind of Business/Industry <i>Mercy Hospital</i>	
17. Father's Name (First, Middle, Last) <i>Davis Hornson</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>ALMA</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Sandra B Johnson NIECC</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1814 New Castle Road Baltimore Md 21244</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Memorial Park</i>		20c. Location - City or Town, State <i>Arbutus, Maryland</i>					
21. Signature of Funeral Service Licensee <i>Debra Davis</i>				22. Name and Address of Facility <i>CHATHAM-HARRIS FUNERAL HOME 5240 Reisterstown Rd Baltimore Md 21235</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death	
a. <i>ALZHEIMER'S DEMENTIA</i> Due to (or as a consequence of):				b. <i>MULTIPLE TIA'S</i> Due to (or as a consequence of):				More than 10 yrs.	
c. <i></i> Due to (or as a consequence of):				d. <i></i> Due to (or as a consequence of):					
IF FEMALE:		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? <i>NO COLON CANCER.</i>				23f. Did alcohol contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <i>8/26/06</i>		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Baltimore MD 21239</i>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <i>D22652</i>				29d. Date signed (Month, Day, Year) <i>9/26/06</i>	
29b. Signature and title of certifier <i>S. Srinivas</i>				29e. Registrar's Signature <i>Debra Davis</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. S. Srinivas 5201 LOCHRAVEN BLVD BALTIMORE MD 21239</i>									
31. Date filed (Month, Day, Year) <i>SEP 29 2006</i>				32. Registrar's Signature					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30909  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY J. DAVIDSON</b>							2. Date of Death Month <b>09</b> Day <b>21</b> Year <b>2006</b>		3. Time of Death <b>4:30 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>			4b. City, Town, or Location of Death <b>Rosedale</b>			4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>219-28-7691</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>72</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Feb. 20, 1934</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Baltimore County</b> 10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>									
	10e. Street and Number <b>4 Elinor Avenue</b>			10f. Zip Code <b>21236</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 yrs.</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>			16b. Kind of Business/Industry <b>Insurance Co.</b>			
	17. Father's Name (First, Middle, Last) <b>Carmello Masscro</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Battaglia</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Harry E. Davidson (Husband)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 Elinor Avenue Baltimore, Md. 21236</b>						
Physician /Medical Examiner	20a. Method of Disposition <b>XXX Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>	Date <b>10-2-2006</b>	20c. Location - City or Town, State <b>Baltimore, Md.</b>						
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>E. J. Lassahn</b>	22. Name and Address of Facility <b>Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236</b>								
	23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiopulmonary Arrest</b> Approximate Interval Between Onset and Death									
	Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiopulmonary Arrest Due to (or as a consequence of):</b>									
	b. <b>Sepsis</b> Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>									
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>			24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> 24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day Year) <b>1 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b>			28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>									
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>									
	29b. Signature and title of certifier <b>Dr. Alireza Shabani-Ardali</b>									
	29c. License number <b>RES 00000</b>									
	29d. Date signed (Month, Day, Year) <b>9/27/06</b>									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Alireza Shabani-Ardali 9000 Franklin Square Drive Baltimore MD 21237</b>									
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>									
	32. Registrar's Signature <b>Paul B. Apolis</b>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30910

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death	
	Lula Louise Ensley							Month	Day	Year	3:30 P.M.	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death					
	1155 Walters Mill Rd.			Forest Hill			HARFORD					
Usual Residence of Decedent		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month Day, Year)	9. Birthplace (State or Foreign Country)				
		816-20-4016	1 M 2 F	78 Yrs.	Months	Days	Hours	Min.	10/20/27 BALTIMORE, MD			
To Be Completed by Funeral Director		10a. State	10b. County	10c. City, Town or Location			10d. Inside City Limits					
		MD	Harford	Forest Hill			10d. Inside City Limits					
		10e. Street and Number	10f. Zip Code			10g. Citizen of What Country?						
		1155 Walters Mill Rd	21050			USA						
		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
		1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	1 □ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 X No Specify:			Specify: white.				
		15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
		Elementary Secondary (0-12)			College (1-4 or 5+)			Drill Press Operator C.M. Kemp				
		17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)							
		James H. Alfred			Lula Belle Miller							
		19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
		Richard D. Ensley			1155 Walters Mill Rd., Forest Hill MD 21050							
		20a. Method of Disposition			20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Location - City or Town, State				
		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			Bel Air Mem. Gardens 9-28-A, Bel Air, MD							
		21. Signature of Funeral Service Licensee			22. Name and Address of Facility							
		Kimberly A. Kupotay			Forest Hill MD 21050. Evans Funeral Chapel - Bel Air, 3 Newport Dr.							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death							
		Immediate Cause (Final disease or condition resulting in death)			6 MONTHS							
		a. LUNG CANCER										
		Due to (or as a consequence of):										
		b. MEDIASTINAL METASTASIS										
		Due to (or as a consequence of):										
		c. _____			Due to (or as a consequence of):							
		d. _____										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) _____			23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
		CHRONIC OBSTRUCTIVE PULMONARY DISEASE										
		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 X Probably 4 □ Unknown										
		24a. Was an autopsy performed? 1 □ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No										
		25. Was case referred to medical examiner? 1 □ Yes 2 X No										
		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)										
		27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide										
		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 X No										
		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
		29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		29b. Signature and title of certifier D. Sharpen MD										
		29c. License number D 31856										
		29d. Date signed (Month, Day, Year) 09/27/2006										
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DISH SHARPE, MD 602 S. ATWOOD RD #106 BEL AIR MD 21014										
		31. Date filed (Month, Day, Year) SEP 29 2006										
		32. Registrar's Signature Dish Sharpe										

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importantly, if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30911

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Sheridan England

2. Date of Death

Month Day Year  
Sept. 25, 2006

3. Time of Death

3:20 P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

To Be Completed by Funeral Director

5. Social Security Number

217-12-8378

Usual Residence of Decedent

Maryland

10a. State

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

2719 Chestnut Hill Rd.

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1  Never Married 2  Married  
3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sole Cutter

16b. Kind of Business/Industry

Shoe Manufacturer

17. Father's Name (First, Middle, Last)

Howard Melvin England

19a. Informant's Name/Relationship (Type, Print)

David A. England/ Son

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Virginia Smithson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1900 Churchville Rd. #A, Bel Air, Maryland 21015

Date

20c. Location - City or Town, State

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial

9-29-06

21. Signature of Funeral Service Licensee

▶ Stephen A. Murphy

22. Name and Address of Facility

McComas Funeral Home, P. A.

50 West Broadway, Bel Air, Maryland 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

3 days.

a. Sepsis

Due to (or as a consequence of):

- Secondary to Urinary Tract Infection

b.

Due to (or as a consequence of):

and Pneumonia

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No

9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy  
4  Pregnant at time of death 5  Other (Specify)  
9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

25. Was case referred to medical examiner?

1  Yes 2  No

27. Manner of Death

1  Natural

2  Accident

3  Suicide

4  Homicide

5  Pending investigation

6  Could not be determined

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4  Nursing Home 5  Residence 6  Other (Specify)

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1  Yes 2  No

28d. Describe how injury occurred

M

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ J. Kevin Lynch MD

29c. License number

D35012

29d. Date signed (Month, Day, Year)

September 27, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Kevin Lynch MD 2 North Ave. Bel Air, Md. 21014

31. Date filed (Month, Day, Year)

SEP 29 2006

32. Registrar's Signature

▶ Jason A. Sparto

England Charles M122604  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30912

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death P.M.			
	Joanne Elizabeth Ferguson							September 26 2006			2:58 P.M.			
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death						
	Gulf Coast Center			Towson				Baltimore						
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 75	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct. 23, 1930	9. Birthplace (State or Foreign Country) Ohio						
	293-24-1282													
Usual Residence of Decedent														
10a. State		10b. County		10c. City, Town or Location							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Delaware				Baltimore										
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?						
3125 Chesley Ave.				21234				U.S.A.						
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE					
Elementary/Secondary (0-12) 12 yrs.			College (1-4 or 5+) 21 yrs.			15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) E.C.O.C. + C.A.L.			16b. Kind of Business/Industry Phoenix Residential Center		
17. Father's Name (First, Middle, Last) Lester			18. Mother's Name (First, Middle, Maiden Surname) Mary McGinty											
19a. Informant's Name/Relationship (Type, Print) Margaret M. Miller			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Johnson Mill Road Forest Hill Maryland 21050											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery			Date Oct. 26, 2006			20c. Location - City or Town, State Evan, Maryland					
21. Signature of Funeral Service Licensee D. T. C. & Associates			22. Name and Address of Facility EVENING OF MEMORIES 8800 HARFORD ROAD PARKVILLE MARYLAND 21234											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death months		
Immediate Cause (Final disease or condition resulting in death)			a. Due to (or as a consequence of): Lily Cancer											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			b. Due to (or as a consequence of):											
			c. Due to (or as a consequence of):											
			d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) hospice			27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred X		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D 58303			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier A. C. Brumme			29d. Date signed (Month, Day, Year) September 26 2006											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aaron Charles mg 6001 n. Charles Sr Brumme and 21204														
31. Date filed (Month, Day, Year) SEP 29 2006			32. Registrar's Signature James B. Becker											

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 5 per fm 8859 9-29-06 mt

State of Maryland, Department of Health and Mental Hygiene 2006 30913

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 28a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner will be notified at  
once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
<i>JAMES GREGOREK</i>		September 27 2006		6:30 AM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
<i>The Johns Hopkins Hospital</i>		<i>Baltimore</i>		<i>N/A</i>	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 27, 1920
216-01-4661					9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent					
10a. State Maryland	10b. County Baltimore County	10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 7125 E. Baltimore Street		10f. Zip Code 21224		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Salesman			16b. Kind of Business/Industry Dennis Advertising
17. Father's Name (First, Middle, Last) Benjamin Gregorek		18. Mother's Name (First, Middle, Maiden Surname) Alexandra Monewski			
19a. Informant's Name/Relationship (Type, Print) Mrs. Regina Gregorek (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7125 E. Baltimore Street, Baltimore Maryland 21224			
20a. Method of Disposition 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel		20c. Location - City or Town, State Sept. 30, 2006 Forest Hill, Maryland	
21. Signature of Funeral Service Licensee <i>Jean J. Le Brun</i>		22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road, Timonium, Maryland 21093			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertension					
Approximate Interval Between Onset and Death 15 years					
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	
		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number RES-000			
29b. Signature and title of certifier <i>MICHAEL AWAD MD</i>		29d. Date signed (Month, Day, Year) September 27, 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL AWAD 600 N. WOLFE ST. BALTIMORE, MARYLAND 21287		31. Date filed (Month, Day, Year) SEP 29 2006			
32. Registrar's Signature <i>James B. Awad</i>					

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30914

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

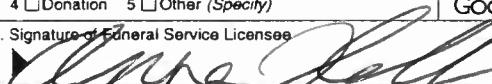
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Bianchina Graziosi		SEPT 25 2006				2:40 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
GOOD SAMARITAN HOSPITAL		BALTIMORE				N/A	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 4, 1929	9. Birthplace (State or Foreign Country) Italy
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 4021 Echodale Avenue		10f. Zip Code 21206			10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Seamstress		16b. Kind of Business/Industry Clothing			
17. Father's Name (First, Middle, Last) Francesco Carota		18. Mother's Name (First, Middle, Maiden Surname) Margherita Neri					
19a. Informant's Name/Relationship (Type, Print) Paolo Graziosi (son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 W. Penn Street, New Freedom, PA 17349					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Maus. 9/29/06		Date			20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
a. <b>GENERALIZED SEPSIS</b> Due to (or as a consequence of):							
b. <b>ABDOMINAL ABSCESS</b> Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. _____							
Approximate Interval Between Onset and Death							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
23f. RESPIRATORY FAILURE ATRIAL FIBRILLATION RENAL FAILURE				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				M			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD					
		29c. License number RES 000					
		29d. Date signed (Month, Day, Year) Sept 25th 2006					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALIM RAGHLI - GOOD SAMARITAN HOSPITAL		5601 LOCH RAVEN BLVD BALTIMORE - MD - 21239					
31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend item#8, per H.G. 860, 10/3/06 T/F  
1- For State Registrar Certificate of Death Reg. No. 2006 30915

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Henry Charles Gunst</b>							2. Date of Death Month <b>09</b> Day <b>26</b> Year <b>2006</b>	3. Time of Death <b>0647 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>7/30/1910</b>			
Funeral Director	5. Social Security Number <b>142-10-2661</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>95 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Jan. 30, 1910</b>	9. Birthplace (State or Foreign Country) <b>Denmark</b>		
	Usual Residence of Decedent		10a. State <b>Maryland</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Baltimore</b>	10d. Inside City Limits <b>1 Yes 2 No</b>
To Be Completed by Funeral Director	10e. Street and Number <b>830 W. 40th Street</b>			10f. Zip Code <b>21211</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
Physician /Medical Examiner	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>		16b. Kind of Business/Industry <b>Chemist</b>			17. Father's Name (First, Middle, Last) <b>Rolf H.L.S. Gunst</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Agnes Hansen</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Peter Gunst (Son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>117 West Hill Street Baltimore, Maryland 21230</b>			Date <b>9-30-2006</b>		20c. Location - City or Town, State <b>Ellicott City, Maryland</b>		
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Good Shepherd Cemetery</b>			20c. Location - City or Town, State <b>Ellicott City, Maryland</b>		22. Name and Address of Facility <b>Wilkie Funeral Homes, Inc.</b>		
	21. Signature of Funeral Service Licensee 		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Congestive Heart Failure</b>			Approximate Interval Between Onset and Death		23b. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____		
	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____		23d. Date of delivery Month Day Year			23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No		
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, Maryland</b>
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D35102</b>			29d. Date signed (Month, Day, Year) <b>September 27 2006</b>				
	29b. Signature and title of certifier 		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Hilary Don M.D. 5901 north Charles street Baltimore maryland</b>							
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,  
Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30916

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death	3. Time of Death	
	MINNIE E. GREEN				Month Day Year SEPT. 28 2006	1:20 P.M.	
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death	4c. County of Death	
	STELLA MARIS HOSPICE				TIMONIUM	LUTHERVILLE	
To Be Completed by Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
	219-18-0046	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	84 Yrs.	Months Days	Hours Min.	Month Day Year OCT. 11 1921	MARYLAND
Usual Residence of Decedent							
MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 514 WYANOKE AVENUE				10f. Zip Code 21218	10g. Citizen of What Country? USA		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) 12TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BENEFITS CLERK		16b. Kind of Business/Industry SOCIAL SECURITY ADM.			
17. Father's Name (First, Middle, Last) JOHN CHASE		18. Mother's Name (First, Middle, Maiden Surname) MINNIE MACKLE					
19a. Informant's Name/Relationship (Type, Print) CHARLES GREEN (SON)							
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 542 WYANOKE AVE, BALTO, MD, 21218							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)							
20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK 10-04-06 WOODLAWN, MARYLAND							
21. Signature of Funeral Service Licensee Dietrich N. Williams							
22. Name and Address of Facility JOSEPH A. BROWN JR. FUNERAL HOME 2145 N. FULTON AVE., BALTO, MD, 21217							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTIPLE MYELOMA							
Approximate Interval Between Onset and Death							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier DR. TARIQ MAHMOOD				29c. License number D43725		29d. Date signed (Month, Day, Year) 9/28/06	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093							
31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature John B. Jacobs					

SEPTEMBER 28, 2006 1:20 P.M.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, W.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30917  
Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Anne McClean Govreau</b>							2. Date of Death Month <b>9</b> Day <b>25</b> Year <b>06</b>	3. Time of Death <b>6 07 PM</b>
4a. Facility Name (If not institution, give street and number) <b>Edenwald</b>				4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>212-09-5730</b>		6. Sex <b>1 □ M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>99 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>July 3, 1907</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	

Funeral  
Director

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Towson</b>	10d. Inside City Limits <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>
10e. Street and Number <b>800 Southerly Rd.</b>			10f. Zip Code <b>21286</b>
10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <b>1 □ Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 □ Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 □ Yes 2 <input checked="" type="checkbox"/> No Specify:</b>	14. Race - American Indian, Black, White, etc. <b>white</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>secretary</b>	16b. Kind of Business/Industry <b>oil company</b>	
17. Father's Name (First, Middle, Last) <b>William McClean</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Crowthers</b>	

19a. Informant's Name/Relationship (Type, Print) <b>Rose E. Halstead/sister</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1055 W. Joppa Rd., #449 Towson, MD 21204</b>
--	--

20a. Method of Disposition <b>1 □ Burial 2 <input checked="" type="checkbox"/> Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount crematory</b>	Date	20c. Location - City or Town, State <b>Sep. 27, 2006 Baltimore, Maryland</b>
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21. Signature of Funeral Service Licensee <b>John O. Mitchell</b>	22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212</b>
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>2 yrs 10 yrs</b>
<p>a. Due to (or as a consequence of): <b>Gundstage Alzheimer's Disease</b></p> <p>b. Due to (or as a consequence of): <b>Alzheimer's disease</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>				

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No 9 □ Unknown</b>	23c. If yes, outcome of pregnancy <b>1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown</b>	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No 3 □ Probably 4 □ Unknown</b>
--	--	--	--	--

25. Was case referred to medical examiner? <b>1 □ Yes 2 <input checked="" type="checkbox"/> No</b>	Hospital: <b>1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA</b>	Other: <b>4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)</b>
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27. Manner of Death <b>1 □ Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide</b>	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work <b>M 1 □ Yes 2 □ No</b>	28d. Describe how injury occurred
---	--	---------------------	--	-----------------------------------

29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>	29b. Signature and title of certifier <b>Dr. Anne McClean</b>	29c. License number <b>D 29769</b>	29d. Date signed (Month, Day, Year) <b>9/25/06</b>
--	--	---------------------------------------	---

30. Name and address of person who completed cause of death (Item 28a) (Type, Print) <b>Anne McClean, MD 816 N. Rolling Rd. Parkville, MD 21228</b>	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>	32. Registrar's Signature <b>Anne B. Smith</b>
--	---	---

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30918

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Important: If Item 27 is marked other than "natural", or Items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>ANNE GINSBERG</i>		SEPTEMBER 27, 2006		3:05 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>NORTHWEST HOSPITAL CENTER</i>		<i>RANDALLSTOWN</i>		<i>BALTIMORE</i>
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days Hours Min. 01/01/1914
8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location OWINGS MILLS
10e. Street and Number 4730 ATRIUM COURT APT. 411		10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HOMEMAKER		16b. Kind of Business/Industry OWN HOME
17. Father's Name (First, Middle, Last) SOLOMON		18. Mother's Name (First, Middle, Maiden Surname) SARAH		FRANK
19a. Informant's Name/Relationship (Type, Print) DAVID GINSBERG / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 SPRUCE COURT - OWINGS MILLS, MD 21117		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) CHIZUK AMUNO CONG.		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 09/28/2006
21. Signature of Funeral Service Licensee <i>Matt Lew</i>		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 18900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		20c. Location - City or Town, State BALTIMORE, MD
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ATRIAL FIBRILLATION; SECULAR disorder depression</i>		23d. Date of delivery Month Day Year		
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) 9/Unknown		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
29b. Signature and title of certifier <i>Dave Lew</i>		29c. License number D19502		29d. Date signed (Month, Day, Year) SEPTEMBER 27, 2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRISTIANO R. GONZALEZ MD		31. Date filed (Month, Day, Year) SEP 29 2006		
32. Registrar's Signature <i>Leanne H. Miller</i>				

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30919

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gloria May Higdon</b>							2. Date of Death Month Day Year <b>September 27 2006</b>	3. Time of Death <b>8:30 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Baltimore-Washington Medical Center</b>			4b. City, Town, or Location of Death <b>Glen Burnie</b>			4c. County of Death <b>Anne Arundel</b>				
Funeral Director	5. Social Security Number <b>218-14-4820</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 29, 1923</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Linthicum</b>							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>104 North Longcross Rd</b>				10f. Zip Code <b>21090</b>			10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>							
17. Father's Name (First, Middle, Last) <b>Chester I. Edie</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ada Carr</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Melissa Barker Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7166 Springhouse Ln, Baltimore, MD 21226</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Karen G. Higdon M01148</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Nat'l Cem</b>			Date <b>Sept 29, 2006</b>	20c. Location - City or Town, State <b>Baltimore, MD</b>				
21. Signature of Funeral Service Licensee <b>Karen G. Higdon M01148</b>			22. Name and Address of Facility <b>Fink Funeral Home, P.A. 426 Crain Hwy S, Glen Burnie, MD 21061</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cerebrovascular accident</b>									Approximate Interval Between Onset and Death		
b. Due to (or as a consequence of): <b>Hypertension</b>											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>									
29b. Signature and title of certifier <b>Karen G. Higdon</b>		29c. License number <b>D43977</b>			29d. Date signed (Month, Day, Year) <b>September 27 2006</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gloria May Higdon, 301 Hospital Dr., Glen Burnie, MD 21061</b>		31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>									
32. Registrar's Signature <b>Karen G. Higdon</b>											

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

GLORIA HIGDON  
Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
2006 30920  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY WEER HAIGHT</b>							2. Date of Death Month <b>09</b> Day <b>28</b> Year <b>2006</b>	3. Time of Death <b>04 10 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>CARROLL HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>WESTMINSTER</b>			4c. County of Death <b>CARROLL</b>	
Funeral Director	5. Social Security Number <b>212-40-6460</b>		6. Sex <b>M</b>	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>July 25 1941</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Carroll</b>	10c. City, Town or Location <b>Sykesville</b>					10d. Inside City Limits <b>Yes</b>	
10e. Street and Number <b>6409 Hillcrest Road</b>				10f. Zip Code <b>21784</b>			10g. Citizen of What Country? <b>USA</b>		
Physician / Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>+3</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)      College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>funeral director</b>			16b. Kind of Business/Industry <b>funeral service</b>		
17. Father's Name (First, Middle, Last) <b>Luther Hush Haight</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Kathryn Iola Haslup</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Susan D. Haight (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6409 Hillcrest Rd., Sykesville, MD 21784</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springfield Cemetery</b>			Date <b>10-2-06</b>	20c. Location - City or Town, State <b>Sykesville, MD</b>	
21. Signature of Funeral Service Licensee <b>Brian L. Haight M00764</b>				22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, MD 21784</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>PULMONARY FIBROSIS</b>									Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SCHEMATIC HEART DISEASE</b> <b>HYPERLIPIDEMIA</b>									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D0058580</b>					29d. Date signed (Month, Day, Year) <b>09/28/2006</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BAI KANU 3233 SUPERIOR LN. B21 BOWIE, MD 20715</b>									
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>				32. Registrar's Signature <b>[Signature]</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30921

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Rose Marie Haglauer		September 27, 2006		1:19 am M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
104 Yawmeter Drive		Middle River		Baltimore
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	8. Date of Birth (Month, Day, Year) Jan. 9, 1936
If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		9. Birthplace (State or Foreign Country) Maryland
10a. State Maryland		10b. County Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10c. City, Town or Location Middle River				
10e. Street and Number 104 Yawmeter Drive		10f. Zip Code 21220		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		14. Race - American Indian, Black, White, etc. Specify: White
17. Father's Name (First, Middle, Last) Earl McCready		18. Mother's Name (First, Middle, Maiden Surname) Ethel Thomas		
19a. Informant's Name/Relationship (Type, Print) Thomas Haglauer (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Yawmeter Drive, Baltimore, Maryland 21220		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221		
23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 12 months		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
a. Due to (or as a consequence of):  Metastatic non small cell lung cancer				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 455-30		29d. Date signed (Month, Day, Year) 9-27-2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Siva Salam, Suite 208, 9114 Philadelphia Road, Baltimore MD 21237				
31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature 		

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2006 30922

## *Certificate of Death*

**Reg. No.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Physician /Medical Examiner**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death			
Daisy Viola Henderson	September 27, 2006 1:45 P M				
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
29 Bonnie Avenue	Bel Air	Harford			
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 97	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 17, 1909	9. Birthplace (State or Foreign Country) Virginia
Usual Residence of Decedent			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State	10b. County	10c. City, Town or Location			
Maryland	Harford	Bel Air			
10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?		
325 Fulford Avenue	21014		USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Part Number Operator	16b. Kind of Business/Industry Aircraft Manufacturer		
17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)				
George Clinton Baldwin	Mahala Ann Blevins				
19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Bonita Kreiner / Daughter	29 Bonnie Ave., Bel Air, MD 21014				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State		
	Darlington Cemetery	10-2-06	Darlington, Maryland		
21. Signature of Funeral Service Licensee <i>Charles A. Engel</i>	22. Name and Address of Facility McComas Funeral Home, P.A.	1317 Cokesbury Road, Abingdon, Maryland 21009			
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death one year.				
Immediate Cause (Final disease or condition resulting in death)					
a. <i>Atherosclerotic cardiovascular disease</i> Due to (or as a consequence of):					
b. _____ Due to (or as a consequence of):					
c. _____ Due to (or as a consequence of):					
d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown	3 <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Daughter's Residence</i>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Mark Weller</i>	29c. License number d 35522	29d. Date signed (Month, Day, Year) September 28, 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MARK WELL AND DAUGHTER HOME BEL AIR MARYLAND 21014</i>					
31. Date filed (Month, Day, Year) SEP 29 2006	32. Registrar's Signature <i>Alma L. Parker</i>				

**State Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30923

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

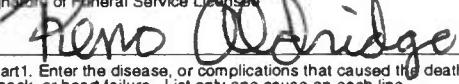
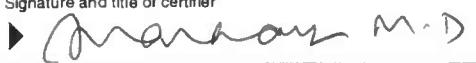
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28 or 28-a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Ronald Darrell Hall		September 22 2006				6:30 P.M.	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
213 Foxridge Court		Glen Burnie				Anne Arundel	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) July 22, 1953	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie					
10e. Street and Number 213 Foxridge Court			10f. Zip Code 21061			10g. Citizen of What Country? U.S.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Viet Nam		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Short order cook			Restaurant
17. Father's Name (First, Middle, Last) Henry Hall				18. Mother's Name (First, Middle, Maiden Surname) Ruby Hale			
19a. Informant's Name/Relationship (Type, Print) Sonja Carr / sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Foxridge Court Glen Burnie, Maryland 21061					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD State Veteran Cem.		Date 9/28/2006		20c. Location - City or Town, State Crownsville, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): b. _____ c. _____ d. _____ Approximate Interval Between Onset and Death, if known							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number D39505		29d. Date signed (Month, Day, Year) September 25, 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhistha Maranjan 305 Hospital Dr. Glen Burnie MD 21061							
31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30924  
Reg. No.

1- For State Registrar		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year			3. Time of Death PM	
Physician /Medical Examiner		ROBIN HOPKINS				Sept 23 2006			245 PM	
Funeral Director		4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSP			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death N/A		
		5. Social Security Number 213 70 7148		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Feb. 19, 1956	9. Birthplace (State or Foreign Country) Maryland	
		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director		10e. Street and Number 712 Richwood Avenue			10f. Zip Code 21212			10g. Citizen of What Country? U.S.		
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			16b. Kind of Business/Industry Restaurant		
		17. Father's Name (First, Middle, Last) Thomas George Trhlik				18. Mother's Name (First, Middle, Maiden Surname) Jane Louise Bittner				
		19a. Informant's Name/Relationship (Type, Print) Jane Bittner / mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Church Street Baltimore, Maryland 21225					
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Piers Aldridge		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 9/26/2006		20c. Location - City or Town, State Baltimore, Maryland		
		21. Signature - Funeral Service Licensee		22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225						
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Anoxic Brain Injury			Approximate Interval Between Onset and Death days			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): Meningoencephalitis						
		23d. Date of delivery Month Day Year								
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		29b. Signature and title of certifier JEFFREY J. PILLING MD		29c. License number D0053722			29d. Date signed (Month, Day, Year) Sept 23 2006			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY J. PILLING MD		31. Date filed (Month, Day, Year) SEP 29 2006			32. Registrar's Signature Jeffrey J. Pillings			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification; To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

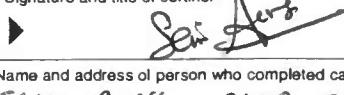
State Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2006 30925

**Reg. No.**

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Kevin Michael Hyman, Sr.</b>						2. Date of Death Month Day Year <b>September 25, 2006</b>			3. Time of Death <b>4:30 A M</b>			
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>19 Freedom Court</b>			4b. City, Town, or Location of Death <b>Middle River</b>			4c. County of Death <b>Baltimore Co.</b>						
To Be Completed by Funeral Director		5. Social Security Number <b>219-44-9590</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Sept. 20, 1947</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
		Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number <b>19 Freedom Court</b>						10f. Zip Code <b>21220</b>			10g. Citizen of What Country? <b>United States</b>			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify:				
		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>1 Year</b>			16b. Kind of Business/Industry <b>Parts Manager</b>			16c. Date of Death <b>Anderson Auto.</b>				
		17. Father's Name (First, Middle, Last) <b>Anthony J. Hyman, Sr.</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Moran</b>							
		19a. Informant's Name/Relationship (Type, Print) <b>Celina J. Hyman (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19 Freedom Court Middle River, Maryland 21220</b>										
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Hilltop Service Corp.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>			Date <b>9/29/2006</b>	20c. Location - City or Town, State <b>Towson, Maryland</b>						
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b> <b>7922 Wise Ave. Dundalk, Maryland 21222</b>												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>METASTATIC COLON CANCER</b>		23b. Due to (or as a consequence of):  <b>SIX YEARS</b>												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):												
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>CIRRHOSIS OF LIVER</b> <b>HEPATITIS C INFECTION</b>		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 		29c. License number <b>J-51555</b>			29d. Date signed (Month, Day, Year) <b>09/25/2006</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SEIN AUNG, 9103 FRANKLIN SQUARE DRIVE, #2200, BALTIMORE MD 21237</b>														
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature 												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30926

Reg. No.

1- For  
State  
Registrar

<b>Physician /Medical Examiner</b>  <div style="float: right; font-size: small; margin-top: -20px;"> <small>Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.</small> </div>	1. Decedent's Name (First, Middle, Last) <b>Pearl R. Julian</b>				2. Date of Death Month <b>Sept.</b> Day <b>28</b> Year <b>2006</b>		3. Time of Death <b>9:25 a M</b>			
	4a. Facility Name (If not institution, give street and number) <b>Sunrise Assisted Living</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>			
<b>Funeral Director</b>	5. Social Security Number <b>129-14-0448</b>			6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>		7. Age (In yrs. last birthday) <b>90 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Sept. 4, 1916</b>		
	9. Birthplace (State or Foreign Country) <b>Greensburg, PA</b>			10. Usual Residence of Decedent MD <b>10a. State</b> <b>Anne Arundel</b> <b>10b. County</b>		10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <b>X <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
<b>To Be Completed by Funeral Director</b>	10e. Street and Number <b>800 Best Gate Road</b>				10f. Zip Code <b>21401</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> <small>If Yes, Give Year or Dates:</small>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> <small>Specify:</small>			14. Race - American Indian, Black, White, etc. <b>Specify: white</b>		
<b>To Be Completed by Physician/Medical Examiner</b>	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 3 reg. nurse</b>			16b. Kind of Business/Industry <b>Met Life-Med</b>			
	17. Father's Name (First, Middle, Last) <b>Ernest J. P. Johnson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Fenstermacher</b>					
<b>Physician /Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <b>Peter H. Julian / son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2920 Winters Chase Way, Annapolis, md 21401</b>						
	20a. Method of Disposition <b>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Westmoreland County Memorial Park</b>			20c. Date <b>Oct. 2, 2006</b>			20c. Location - City or Town, State <b>Greensburg, PA</b>
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Charles L. Stevens Funeral Home INC. 1501 East Fort Avenue, Baltimore, MD 21230</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <small>Immediate Cause (Final disease or condition resulting in death)</small>						Approximate Interval Between Onset and Death			
23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>						23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>				
23d. Date of delivery Month <b>Oct.</b> Day <b>2</b> Year <b>2006</b>						23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>				
24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>						24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>				
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) <b>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ass. living</b>				27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>				
28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>		28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		28d. Describe how injury occurred <b>ass. living</b>						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>						29b. Signature and title of certifier 				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Aditya Chopra MD, 600 Ridgley Ave. #231 Annapolis, MD 21401</b>						29c. License number <b>D57028</b>				
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>						29d. Date signed (Month, Day, Year) <b>Sept. 29, 2006</b>				

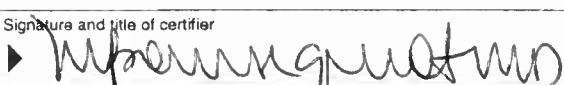
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2006 30927

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID JENKINS</b>							2. Date of Death Month Month Day Day Year Year <b>September 23 2006</b>		3. Time of Death 12:06 PM	
	4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>			4b. City, Town, or Location of Death <b>Columbia</b>			4c. County of Death <b>Howard</b>				
Funeral Director	5. Social Security Number <b>136-26-9932</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Feb. 20, 1938</b>	9. Birthplace (State or Foreign Country) <b>Washington D.C.</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Talbot</b> 10c. City, Town or Location <b>Easton</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	10e. Street and Number <b>29651 Charles Drive</b>			10f. Zip Code <b>21601</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1938</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assistant Deputy Commissioner of Human Relations</b>			16b. Kind of Business/Industry <b>Social Security</b>				
	17. Father's Name (First, Middle, Last) <b>Alfred Jenkins</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Jones</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Judy Jenkins (Wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>29651 Charles Drive Easton, Maryland 21601</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Meadowridge</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge</b>			Date <b>9-29-2006</b>	20c. Location - City or Town, State <b>Elkridge, Maryland</b>			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Witzke Funeral Homes, Inc.</b> <b>5555 Twin Knolls Road Columbia, MD 21045</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Arrhythmia</b>								Approximate Interval Between Onset and Death		
	b. Due to (or as a consequence of): <b>Hyperlipidemia</b>										
	c. Due to (or as a consequence of):										
	d. _____										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BPH, ED</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 				29c. License number <b>D0051958</b>		29d. Date signed (Month, Day, Year) <b>September 23, 2006</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARIE BOURSIQUOT, M.D. 5450 Knoll North Drive Ste 100 Columbia MD 21045</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>			32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30928

For  
State  
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Patricia Jesters</i>						2. Date of Death Month 09 Day 26 Year 2006	3. Time of Death 1526 PM
Funeral Director	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Med. Ctr.</i>			4b. City, Town, or Location of Death <i>Bethesda</i>		4c. County of Death <i>MD</i>		
	5. Social Security Number 216-70-4088	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F XX	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 18, 2006	9. Birthplace (State or Foreign Country) Maryland	

To Be Completed by Funeral Director

Usual Residence of Decedent		10a. State Maryland 10b. County Howard 10c. City, Town or Location Jessup						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No XX
10e. Street and Number 8265 Lincoln Drive				10f. Zip Code 20794			10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Deli				
17. Father's Name (First, Middle, Last) Robert Charles Howes, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Grace Grimes				
19a. Informant's Name/Relationship (Type, Print) James C. Jesters, Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8265 Lincoln Drive Jessup, Maryland 20794				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. PK			Date 9/30/2006	20c. Location - City or Town, State Dorsey, MD		
21. Signature of Funeral Service Licensee <i>▶ Greg Skp</i>				22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707				

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death				
a. Due to (or as a consequence of): <i>Necrotizing Fasciitis</i>		1 MONTH				
b. Due to (or as a consequence of): <i>Abdominal Sepsis</i>		1 month				
c. Due to (or as a consequence of): <i>Pneumonia</i>		1.5 MONTH				
d. Due to (or as a consequence of): <i>Perforated Appendicitis</i>		1 MONTH				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COPD, Asthma, Steroid dependent, Ioom</i>						
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				

State  
Registrar

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>P17377</i>		29d. Date signed (Month, Day, Year) <i>9-26-06</i>
29b. Signature and title of certifier <i>R. Burton Jr. DMMC</i>		32. Registrar's Signature <i>Jane K. Goss</i>		
31. Date filed (Month, Day, Year) <i>SEP 29 2006</i>		32. Registrar's Signature		

Baltimore, Maryland 21215-0036

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

## Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2006 30929

1- For State Registrar

Physician/  
Medical Examiner

1 Decedent's Name (First, Middle, Last)

Andrew Levi Jackson

2. Date of Death

Month 9 Day  
September 25, 2006

3. Time of Death

0533 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

2300 Mount Royal Terrace

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-96-1689

6. Sex

1  M 2  F

7. Age (In yrs. last birthday)

26

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min

8. Date of Birth (MM/DD/YYYY)

7-11-1980

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

2309 McElderry Street

rear

10f. Zip Code

21205

10g. Citizen of What Country?

N/A

11. Marital Status

1  Never Married2  Married3  Widowed4  Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1  Yes 2  No

If Yes, Give Year

or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done

during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Home Improvement

17. Father's Name (First, Middle, Last)

Andrew Fred Jackson III

18. Mother's Name (First, Middle, Maiden Surname)

Dariene Briscoe

19a. Informant's Name/Relationship (Type, Print)

Dariene Briscoe

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2309 McElderry Street rear

20a. Method of Disposition

1  Burial2  Cremation3  Removal from State4  Donation5  Other Specify:

20b. Place of Disposition (Name of cemetery,

crematory or other place)

TRINITY

Date

UNK

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Phillip A. Weatherford

Signature

22. Name and Address of Facility

2431 E. Oliver Street

Baltimore, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Gunshot Wounds

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

item#10c, per FH.C859, 9/29/06 TT

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth2  Fetal death3  Ectopic pregnancy4  Pregnant at time of death5  Other (Specify)9  Unknown

23d. Date of delivery

Month

Day

Year

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient2  ER/Outpatient3  DOA4  Nursing Home5  Residence6  Other Scene

26. Place of Death (Check only one)

27. Manner of Death

1  Natural2  Accident3  Suicide4  Homicide5  Pending Investigation6  Could not be determined

28a. Date of Injury (Month, Day, Year)

FOUND:

Sep 25, 2006

0330 hrs

28b. Time of Injury

FOUND:

1  Yes2  No

28c. Injury at Work?

1  Yes2  No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Sidewalk

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2300 Mount Royal Terrace, Baltimore, MD

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statedone) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

29b. Signature and title of certifier

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 25, 2006

31. Date filed (Month, Day, Year)

SEP 29 2006

32. Registrar's Signature

Zabiullah Ali

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30930

Reg. No.

1- For State Registrar		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death					
Physician /Medical Examiner		James Jennings		September 26, 2006		7:15 pm					
Funeral Director		4a. Facility Name (If not institution, give street and number) 15 Longeron Drive		4b. City, Town, or Location of Death Middle River		4c. County of Death Baltimore					
To Be Completed by Funeral Director		5. Social Security Number 242-52-8514		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F 7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) 2/10/1938					
		10a. State Maryland		10b. County Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
		10e. Street and Number 15 Longeron Drive		10f. Zip Code 21220		10g. Citizen of What Country? U. S. A.					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: (Unknown)		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Driver		16b. Kind of Business/Industry Trucking					
		17. Father's Name (First, Middle, Last) Frank Jennings		18. Mother's Name (First, Middle, Maiden Surname) Elzora Litamilke							
		19a. Informant's Name/Relationship (Type, Print) Nancy Jennings (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Longeron Drive Middle River, Maryland 21220							
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Oak Lawn Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Date 9/30 2006		20c. Location - City or Town, State Baltimore, Maryland					
		21. Signature of Funeral Service Licensee Michael C. Jaffee, Sr.		22. Name and Address of Facility Brudzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Pancreatic Cancer b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 6 months			
Medical Certification: To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier Dr. Michael Waterfield, MD		29c. License number D0024356		29d. Date signed (Month, Day, Year) 9-27-06					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Waterfield, MD - 9103 Franklin Sq. Dr. Balto, MD. 21237									
		31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

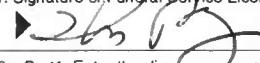
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30931

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Linda Fay Kimbrough</b>							2. Date of Death Month Day Year <b>Sept. 27 2006</b>	3. Time of Death <b>2:18 am</b>
	4a. Facility Name (If not institution, give street and number) <b>7249 Swan Point Way</b>				4b. City, Town, or Location of Death <b>Columbia</b>			4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>416-72-5715</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>55 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Jun. 5, 1951</b>	9. Birthplace (State or Foreign Country) <b>Edgewater, AL</b>	
	Usual Residence of Decedent				Hours	Min.			
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Columbia</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>7249 Swan Point Way</b>				10f. Zip Code <b>21045</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>5+</b> Professor			16b. Kind of Business/Industry <b>Montgomery College</b>	
	17. Father's Name (First, Middle, Last) <b>Eddie Lee Kimbrough</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sallie Mae Brown</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Selessia Kimbrough / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7249 Swan Point Way, Columbia, MD 21045</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>George Washington Carver Cemetery</b>		Date <b>Oct. 7, 2006</b>	20c. Location - City or Town, State <b>Birmingham, AL</b>			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230</b>						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Cervical cancer</b>								
	Approximate Interval Between Onset and Death <b>6 years</b>								
	23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Cervical cancer</b>								
	a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. License number <b>D062234</b>						
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) <b>Sept. 29, 2006</b>						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Manish Agrawal, M.D. 9707 Medical Center Drive, Suite 300, Rockville, MD 20850</b>								
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event,  Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30932  
Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit envelope.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year			3. Time of Death		
BARBARA KNIGHT.		Sept 23 2006 12:00PM				
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			4c. County of Death		
Good Samaritan Hospital		Baltimore			N/A	
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) APRIL 14, 1954	
					9. Birthplace (State or Foreign Country) MD.	
Usual Residence of Decedent						
10a. State MD	10b. County BALTIMORE	10c. City, Town or Location PARKVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3329 TEXAS AVE		10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Clerk			16b. Kind of Business/Industry RESTAURANT	
17. Father's Name (First, Middle, Last) ALLEN HARRIS			18. Mother's Name (First, Middle, Maiden Surname) GLORIA MANN			
19a. Informant's Name/Relationship (Type, Print) GLORIA HARRIS		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3329 TEXAS AVE. BALTO. MD 21234				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BAYVIEW CREMATORY		Date 9/25/06	20c. Location - City or Town, State BALTO MD 21234	
21. Signature of Funeral Service Licensee Paul M. Stells		22. Name and Address of Facility PAUL STELLS FUNERAL HOME, PA 7527 Harbor Rd. BALTO MD 21234				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Small Cell Lung Cancer						
Approximate Interval Between Onset and Death						
Sequently list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatitis C						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D38956				
29b. Signature and title of certifier Edward Seidel MD						29d. Date signed (Month, Day, Year) Sept. 23, 2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward Seidel MD, 5601 Loch Raven Blvd, Baltimore, Maryland 21239						
31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature Barbara B. Stells				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30933  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EMMA HERMANI LINDEMOM</b>							2. Date of Death Month Day Year <b>SEPTEMBER 27, 2006</b>	3. Time of Death <b>08:30AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>212-22-6629</b>	6. Sex <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>February 18, 1913</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Towson</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number <b>1506 East Joppa Road</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Henry Hermani</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Grigoleit</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Alexandra C Lindemon</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>DTR 1506 East Joppa Road Towson, Maryland 21286</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GreenMount Crematory</b>		Date <b>9/28/06</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
	21. Signature of Funeral Service Licensee <i>Kenneth Stephan Kenakes</i>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212</b>					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b>								Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DIVERTICULITIS</b>									
	c. Due to (or as a consequence of): <b>CHRONIC LYMPHOCYTIC LEUKEMIA</b>									
	d.									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COMPLETE HEART BLOCK</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <b>Natural</b> <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) <b>9/27/06</b>	
	29b. Signature and title of certifier 								29c. License number <b>D37254</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BOON POH LIM, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204</b>								31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>	
	32. Registrar's Signature 								33. Date signed (Month, Day, Year)	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30934

1- For State  
Registrar**Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last) <b>James Dennis McCormick</b>						2. Date of Death Month Day Year <b>September 22, 2006</b>	3. Time of Death 1024 hrs
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**Funeral  
Director**

4a. Facility Name (if not institution, give street and number) <b>102 Liberty Street</b>						4b. City, Town, or Location of Death <b>Westminster</b>	4c. County of Death <b>Carroll</b>
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5. Social Security Number <b>367-54-0030</b>	6. Sex <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>55</b>	Yrs. If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>08-01-1951</b>	9. Birthplace (State or Foreign Country) <b>MI</b>
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Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Carroll</b> 10c. City, Town or Location <b>Westminister</b>						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number <b>102 Liberty St.</b>			10f. Zip Code <b>21158</b>	10g. Citizen of What Country? <b>USA</b>
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: <b>White</b>	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Executive</b>	16b. Kind of Business/Industry <b>Air Port Facility</b>
--	--	---	--

17. Father's Name (First, Middle, Last) <b>Wayne P. McCormick</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Doris Kay Sheperd</b>
--	--	--	---

19a. Informant's Name/Relationship (Type, Print) <b>Dara Feldman/friend</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11223 Orleans Way Kensington MD 20895</b>
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>	Date <b>09-27-2006</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility <b>Rapp Funeral &amp; Cremation Service 933 Gist Ave Silver Spring MD 20910</b>
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Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Physician/  
Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		a. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last		b. _____ Due to (or as a consequence of):
		c. _____ Due to (or as a consequence of):
		d. _____

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <b>Chronic Alcohol Abuse</b>	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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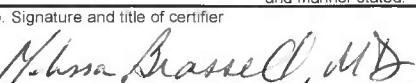
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene		
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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29b. Signature and title of certifier 	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 23, 2006</b>
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30. Name and address of person who completed cause of death (Item 23a) <b>Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>
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31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>	32. Registrar's Signature 
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ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30935

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Evelyn Morris</b>							2. Date of Death Month Day Year <b>Sept. 25, 2006</b>	3. Time of Death 8:20 AM			
	4a. Facility Name (If not institution, give street and number) <b>Good Samaritan Nursing Home</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death -----					
Funeral Director	5. Social Security Number <b>217-05-7255</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months <b>87</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Aug. 25, 1919</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Howard</b> 10c. City, Town or Location <b>Columbia</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number <b>9339 Gentle Folk</b>				10f. Zip Code <b>21045</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1955</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>			16b. Kind of Business/Industry <b>Baltimore City</b>					
	17. Father's Name (First, Middle, Last) <b>Harry F. Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Harvey</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Harry F. Smith (Brother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9339 Gentle Folk Columbia, Maryland 21045</b>							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Metro Crematory</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>			Date <b>9-28-2006</b>	20c. Location - City or Town, State <b>Catonsville, MD</b>				
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. chronic obstructive Pulmonary disease</b> Due to (or as a consequence of): <b>End stage</b> Approximate Interval Between Onset and Death <b>More than one year</b>											
	b. _____ Due to (or as a consequence of):											
	c. _____ Due to (or as a consequence of):											
	d. _____											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Cannot be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>,</b>			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29d. Date signed (Month, Day, Year) <b>September 25th 2006</b>		
	29b. Signature and title of certifier 									29c. License number <b>D 30661</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>5601 Loch Raven Blvd, Baltimore, MD 21239</b>									31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		
	32. Registrar's Signature 									33. Date signed (Month, Day, Year)		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit documents.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30936  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES MAY</b>							2. Date of Death Month Day Year September 28, 2006	3. Time of Death 7:10 a m
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>			4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>155-20-2198</b>	6. Sex <b><input checked="" type="checkbox"/> M <input type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>79 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug. 11, 1927</b>	9. Birthplace (State or Foreign Country) <b>Ohio</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Laurel</b>							10d. Inside City Limits <b><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</b>	
	10e. Street and Number <b>7906 Aylesford Lane</b>				10f. Zip Code <b>20707</b>			10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1945- If Yes, Give Year or Dates: 1948</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 5 + College (1-4 or 5+)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrical Engineer</b>				16b. Kind of Business/Industry <b>Johns Hopkins Applied Physics Lab</b>	
	17. Father's Name (First, Middle, Last) <b>Curtis May</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Springer</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Virginia May / Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4857 Red Hill Way Ellicott City, Maryland 21043</b>					
	20a. Method of Disposition <b><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ivy Hill Cemetery</b>			Date <b>10/02/2006</b>	20c. Location - City or Town, State <b>Laurel, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>GR Springer / M00770</b>			22. Name and Address of Facility <b>Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b>								Approximate Interval Between Onset and Death minutes
	a. <b>Cerebral Thrombosis</b> Due to (or as a consequence of):								
	b. <b>Acute Respiratory Failure</b> Due to (or as a consequence of):								days
	c. Due to (or as a consequence of):								
	d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>			23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown</b>			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Renal Failure</b>								23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>
	<b>Septicemia</b>								24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
									24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			26. Place of Death (Check only one) Hospital: <b>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>					
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>			29b. Signature and title of certifier <b>William A. Warren, M.D.</b>					
				29c. License number <b>D 13916</b>			29d. Date signed (Month, Day, Year) <b>September 28, 2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William A. Warren, M.D. 321 Prince George Street Laurel, Maryland 20707</b>			31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>					
	32. Registrar's Signature <b>Agnes M. Parker</b>								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

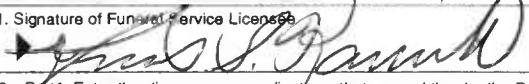
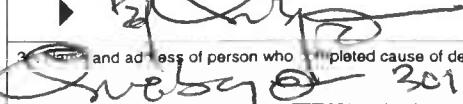
State of Maryland / Department of Health and Mental Hygiene

2006 30937

## Certificate of Death

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RODNEY PORTER McGLOTHLIN</b>							2. Date of Death Month Day Year <b>SEPTEMBER 26 2006</b>	3. Time of Death Hour Minute AM/PM <b>10:50 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>BALTIMORE WASHINGTON MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>Glen Burnie Anne Arundel</b>				4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>220-34-7132</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>65 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>March 24 1941</b>	9. Birthplace (State or Foreign Country) <b>Tennessee</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Pasadena</b>							10d. Inside City Limits <b>1 Yes 2 No</b>			
	10e. Street and Number <b>2953 Crystal Palace Lane</b>			10f. Zip Code <b>21122</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <b>1 Never Married 2 Married</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify: White</b>				14. Race - American Indian, Black, White, etc. <b>Specify: White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b>	16b. Kind of Business/Industry <b>Plant Supervisor</b>				16c. Kind of Business/Industry <b>Manufacturing</b>				
	17. Father's Name (First, Middle, Last) <b>Porter McGlothlin</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Webb</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>Beverly McGlothlin (Wife)</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2953 Crystal Palace Lane, Pasadena, Maryland 21122</b>									
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Cross Cemetery</b>	Date <b>09-29-06</b>				20c. Location - City or Town, State <b>Brooklyn Park, Maryland</b>				
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A., 3204 Mountain Road, Pasadena, Maryland 21122</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ANoxic ENCEPHALOPATHY</b>								Approximate Interval Between Onset and Death		
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DIABETES. MELLITUS</b>										
	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown								23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>								26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>		
	27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b>								28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <b>1 Yes 2 No</b> 28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>								28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Glen Burnie MD 21061</b>		
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>								29b. Signature and title of certifier  <b>MD</b>	29c. License number <b>545149</b>	29d. Date signed (Month, Day, Year) <b>September 26 2006</b>
	31. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Beverly McGlothlin</b>								32. Registrar's Signature 		
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.										
Physician /Medical Examiner	Medical Certification: To Be Completed by Physician/Medical Examiner										
State Registrar	DHMH 17 Rev 1/2001										

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30938

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death			
	HAROLD NATHANIEL MYERS SR.							September 25, 2006 3:50 P M				
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death				
	Greater Baltimore Medical Center				Towson			Baltimore				
	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.			8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)			
	216-28-9491			74 Yrs.				MAY 10 1932	MARYLAND			
	Usual Residence of Decedent											
	10a. State	10b. County		10c. City, Town or Location					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	MARYLAND	BALTIMORE		CHASE								
	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?				
	12146 EASTERN AVENUE				21220			U.S.A.				
	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: BLACK				
	<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		53/54		1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
	Elementary/Secondary (0-12)		College (14-or 5+)		AIR CONDITION/REFRIGERATION			ABERDEEN PROVING GROUND				
	12yrs 1 yr											
	17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)						
	CHARLES R. MYERS					DORA REED						
	19a. Informant's Name/Relationship (Type, Print)									19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
	Shirley D. Myers/Wife									12146 Eastern Ave., Baltimore, Maryland 21220		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State			
					Sharp St U.M.C			09-29-06	CHASE, MARYLAND			
	21. Signature of Funeral Service Licensee <i>Sabrina G</i>									22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN MD 21001		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death)											
	a. <i>Respiratory Failure</i> Due to (or as a consequence of)											
	b. <i>Pneumonia</i> Due to (or as a consequence of)											
	c. <i>Acute Respiratory Distress Syndrome</i> Due to (or as a consequence of)											
	d.											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aspiration Pneumonia</i> <i>Metastatic Squamous Cell Cancer</i>									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier <i>M. Schuman MD</i>		
	29c. License number <i>D-44728</i>									29d. Date signed (Month, Day, Year) <i>09-25-2006</i>		
	30. Name and address of person who informed of cause of death (Item 23a) (Type, Print) <i>Mitchell L. Schuman MD 6535 N Charles St Ste 550</i>									31. Date filed (Month, Day, Year) <i>SEP 29 2006</i>		
	32. Registrar's Signature <i>Jean B. Schuman</i>											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified all sources.

To Be Completed by Funeral Director

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30939  
Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

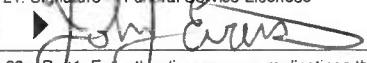
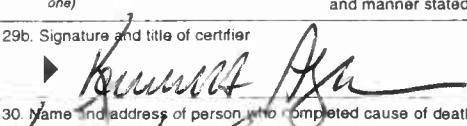
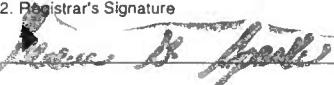
Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death			
<b>Delores J. Maskell</b>	September 25 2006	2308 P M			
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
<b>Good Samaritan Hospital</b>	<b>Baltimore, MD</b>	---			
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov 16, 1939	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent					
10a. State MD	10b. County ----	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 6008 1/2 Burgess Avenue			10f. Zip Code 21214		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inventory Clerk		16b. Kind of Business/Industry Becton Dickenson	
17. Father's Name (First, Middle, Last) John Sanphilipo			18. Mother's Name (First, Middle, Maiden Surname) Esther Dowlin		
19a. Informant's Name/Relationship (Type, Print) Katherine Suter, daughter					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		Date Sept 29, 2006
21. Signature of Funeral Service Licensee 					
22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road, Baltimore, Maryland 21206					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Approximate Interval Between Onset and Death 1 hour					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 					
29c. License number D38543					
29d. Date signed (Month, Day, Year) September 26, 2006 21234					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin J. Scruggs and 5601 Loch Raven Boulevard Ba. Baltimore Maryland					
31. Date filed (Month, Day, Year) SEP 29 2006					
32. Registrar's Signature 					

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30940

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Maas</b>						2. Date of Death Month Sept. Day 26, Year 2006	3. Time of Death 10:00 a.m.	
	4a. Facility Name (If not institution, give street and number) <b>Genesis Hamilton Center</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>220-30-7463</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>January 27, 1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent		10a. State <b>Maryland</b> 10b. County <b>N/A</b>			10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>6040 Harford Road</b>			10f. Zip Code <b>21214</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1946</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plumber</b>			16b. Kind of Business/Industry <b>Plumbing Company</b>		
	College (1-4 or 5+) <b>12</b>								
	17. Father's Name (First, Middle, Last) <b>Eugene A. Maas</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Schruvel</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>John D. Kellum Sr/ Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3039 Fleetwood Avenue Baltimore Maryland 21214</b>				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>►Christine J. Nitton</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>			Date <b>9/28/06</b>	20c. Location - City or Town, State <b>Towson Maryland</b>	
	21. Signature of Funeral Service Licensee <b>John D. Kellum Sr/ Friend</b>			22. Name and Address of Facility <b>Leonard J. Ruck, Inc.</b>			5305 Harford Rd. Baltimore, MD 21214		
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b>								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)  b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  e. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL INSUFFICIENCY</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) <b>SEPTEMBER 26 2006</b>	
29b. Signature and title of certifier <b>Attending Physician</b>		29c. License number <b>DO 06 2239</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>6040 HARFORD ROAD, BALTIMORE, MD 21214</b>									
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30941  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lorene McCauley</b>				2. Date of Death Month Day Year <b>September 23, 2006</b>	3. Time of Death 8:13 P M		
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Hospice Ctr.</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore Co.</b>			
Funeral Director	5. Social Security Number <b>418-26-3647</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <b>Feb. 25, 1925</b>	9. Birthplace (State or Foreign Country) <b>Alabama</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>255 St. Helena Ave.</b>			10f. Zip Code <b>21222</b>	10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 Years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	16b. Kind of Business/Industry <b>Own Home</b>				
	17. Father's Name (First, Middle, Last) <b>William D. Spivey</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Floyd</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Betty McLaughlin (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>255 St. Helena Ave. Dundalk, Maryland 21222</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>CHF</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>	Date <b>9/27/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>J. C. Call</i>		22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b> <b>7922 Wise Ave. Dundalk, Maryland 21222</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>CHF</b>						Approximate Interval Between Onset and Death <b>days</b>	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes, Dementia</b>						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>00051926</b>					
	29b. Signature and title of certifier <i>Helen M. Gordon MD</i>		29d. Date signed (Month, Day, Year) <b>September 24, 2006</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen M. Gordon MD 6585 N. Charles St, Baltimore MD 21204</b>		31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>					
State Registrar	32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at all times.

Division of Vital Records, P.O. Box 68760, MS

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30942

Reg. No.

1- For State Registrar		Decedent's Name (First, Middle, Last) Poppy Phyllis Neal						2. Date of Death Month Month Day Year SEPT 28 2006	3. Time of Death 12:45A M
Physician /Medical Examiner	4a. Facility Name (If not institution, give street and number) Ellicott City Health & Rehab. Ct.						4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard
	5. Social Security Number 217-44-2530		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) JULY 29, 1923	9. Birthplace (State or Foreign Country) England	
Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Howard						10c. City, Town or Location Columbia		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X
10e. Street and Number 7070 Cradlerock Way #120		10f. Zip Code 21044				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Theatrical Entertainer			16b. Kind of Business/Industry Entertainment			
17. Father's Name (First, Middle, Last) Frank Williams				18. Mother's Name (First, Middle, Maiden Surname) Lilian Gertrude Crosby					
19a. Informant's Name/Relationship (Type, Print) Denise F. Cabral - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 Sharp Road Glenelg, MD 21737					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► David McDonald MO0848				20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation			Date 9/29/06	20c. Location - City or Town, State Sykesville, MD	
21. Signature of Funeral Service Licensee ► David McDonald MO0848				22. Name and Address of Facility Haight Funeral Home and Chapel P.O. Box 195 Sykesville, MD 21784 (410-795-1400)					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Due to (or as a consequence of): a. END STAGE CONGESTIVE HEART FAILURE b. HEPATIC CIRRHOSIS c. Due to (or as a consequence of): d. Due to (or as a consequence of):					Approximate Interval Between Onset and Death months months
23c. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier ► Poppy MD					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAKUNMALA GUPTA 9650 SANTIAGO RD SUITE 110				29c. License number DOCS3150			29d. Date signed (Month, Day, Year) SEPT 28 <sup>th</sup> 2006		
31. Date filed (Month, Day, Year) SEP 29 2006				32. Registrar's Signature Leanne B. Appler			33. Location (Street and Number or Rural Route Number, City or Town, State) COLUMBIA MD 21045		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### *Certificate of Death*

2006 30944

**Req. No.**

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)	Fred Nilsen				2. Date of Death Month Day Year	3. Time of Death	
					September 20 2006	9:02 P.M.		
Funeral Director	4a. Facility Name (If not institution, give street and number) <b>Harbor Hospital Center</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>	
	5. Social Security Number <b>155 12 0611</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>June 14, 1918</b>	9. Birthplace (State or Foreign Country) <b>Norway</b>	
Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number <b>5725 Johnson Street</b>				10f. Zip Code <b>21225</b>			10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>6 years</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Civil Engineer</b>			16b. Kind of Business/Industry <b>U.S. Government</b>		
17. Father's Name (First, Middle, Last) <b>unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Harold Jolle / friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14909 Dunstan Lane Monkton, Maryland 21111</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park</b>			Date <b>9/25/2006</b>	20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Reno Aldridge</b>			22. Name and Address of Facility <b>Gonce Funeral Service, P.A.</b> <b>4001 Ritchie Highway Baltimore, Maryland 21225</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last								
<p>a. <i>Acute Cardo pulmonary insufficiency</i> Due to (or as a consequence of):</p> <p>b. <i>Atrial Fibillation</i> Due to (or as a consequence of):</p> <p>c. <i>HTN</i> Due to (or as a consequence of):</p> <p>d. <i>Cardiomyopathy</i></p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
<p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>R. W. Lister MD</b>				29c. License number <b>D14318</b>			29d. Date signed (Month, Day, Year) <b>9/22/06</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert W. Lister MD 3346 Papar Mel Rd, Phoenix MD, 21131</b>								
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>			32. Registrar's Signature <b>John B. Smith</b>					

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**Baltimore, Maryland 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

RHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30945

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death	
	JAMES E PALMITER, JR			September 25 2006 18:39 PM		
Funeral Director	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death Baltimore	4c. County of Death	
	Social Security Number 213-68-4735	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 12-26-1967	9. Birthplace (State or Foreign Country) Maryland
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Edgewood 10e. Street and Number 1539 Charles Town Dr. 10f. Zip Code 21040			10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Married 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Homemaker	16b. Kind of Business/Industry at home			
	17. Father's Name (First, Middle, Last) James E. Palmiter, sr	18. Mother's Name (First, Middle, Maiden Surname) Linda M. Sturgill				
	19a. Informant's Name/Relationship (Type, Print) Leslie Palmiter (spouse)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1539 Charles Town Dr. Edgewood, MD 21040				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel	Date 9/28/06	20c. Location - City or Town, State Forest Hill, MD		
	21. Signature of Funeral Service Licensee John B. Blash	22. Name and Address of Facility Evans Funeral Chapel - Belair 3 Newport Dr. Forest Hill, MD 21050				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARREST Due to (or as a consequence of): b. HEPATIC FAILURE Due to (or as a consequence of): c. ALCOHOLIC HEPATITIS Due to (or as a consequence of): d. _____					Approximate Interval Between Onset and Death 5 MINUTES
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					6 MONTHS
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
	28b. Time of Injury M			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier DANIEL DURANA, MEDICAL DOCTOR		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL DURANA THE JOHNS HOPKINS HOSPITAL, 600 North Wolfe Street, Baltimore, Maryland 21287			29c. License number RES-000		
	31. Date filed (Month, Day, Year) SEP 29 2006			29d. Date signed (Month, Day, Year) SEPTEMBER 25, 2006		
	32. Registrar's Signature John B. Blash					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a per Dr., G859, 09/29/06dhb

Certificate of Death

Reg. No. 2006 30946

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Nadean H. Puryear					2. Date of Death Month Day Year Sept 23, 2006	3. Time of Death 9:10 P M	
	4a. Facility Name (If not institution, give street and number) 8902 Dangerfield Road			4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 228 42 0632	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 18, 1915	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent 10a. State Maryland							
To Be Completed by Funeral Director	10b. County Prince George's	10c. City, Town or Location Clinton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 8902 Dangerfield Road			10f. Zip Code 20735		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: XX		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Seamstress		16c. Location - City or Town, State Dress Making		
17. Father's Name (First, Middle, Last) Archer C. Hite				18. Mother's Name (First, Middle, Maiden Surname) Ada F. Tally				
19a. Informant's Name/Relationship (Type, Print) Jeanette Johnson (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8902 Dangerfield Road, Clinton, Clinton, MD 20735				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) XX		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens		20c. Date Sept 28, 2006		20c. Location - City or Town, State Waldorf, Maryland		
21. Signature of Medical Examiner/Licensee JCHH 6 MO1464		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry, Clinton, MD 20735						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimers							Approximate Interval Between Onset and Death YR
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier Thomas Fieldson, MD		29c. License number 0001923		29d. Date signed (Month, Day, Year) 25 Sept 2006				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Fieldson, MD 2068 Crain Highway, Waldorf, MD 20601								
31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Item 23a or 23a-1 show any injury or other traumatic event, a Medical Examiner must be certified.

#234  
Division of Vital Records, P.O. Box 68760, Baltimore, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30947  
Rag. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANK A. PIERELLI</b>							2. Date of Death Month <b>SEPT - 27</b> Day <b>2006</b> Year	3. Time of Death <b>11:20 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center Baltimore</b>			4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>179-14-0010</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>84 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>01-30-1922</b>	9. Birthplace (State or Foreign Country) <b>PA.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Middle River</b>							10d. Inside City Limits <b>1 Yes 2 No</b>	
	10e. Street and Number <b>112 Cowhide Circle</b>			10f. Zip Code <b>21220</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>	12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No If Yes, Give Year or Dates:</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 years</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Post Office Worker</b>			16b. Kind of Business/Industry <b>Transportation</b>		
	17. Father's Name (First, Middle, Last) <b>Enrico Pierelli</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Cossa</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Judith E. Kuhar Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1514 National Road, Baltimore, Maryland 21234</b>						
Physician /Medical Examiner	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>September 29, 2006</b>	20c. Location - City or Town, State <b>Baltimore City, MD.</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Anthony Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)							Approximate Interval Between Onset and Death	
	a. <b>Hodgkin's lymphoma</b> Due to (or as a consequence of):								
	b. <b>cholestatic liver disease</b> Due to (or as a consequence of):								
	c. <b>Kidney failure</b> Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown</b>			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>	
								24a. Was an autopsy performed? <b>1 Yes 2 No</b>	24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>						
	27. Manner of Death <b>1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>								
	29b. Signature and title of certifier <b>A. Tiffany, MD</b>		29c. License number <b>RES-000</b>			29d. Date signed (Month, Day, Year) <b>09/27/06</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Amanda Tiffany, MD, 4940 Eastern Avenue, Baltimore, MD, 21224</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature <b>Leanne B. Goss</b>						

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30948

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Blanche Rebecca Reinhart</b>							2. Date of Death Month Sept Day 26 Year 2006	3. Time of Death 11:20 AM	
	4a. Facility Name (If not institution, give street and number) <b>Fort Washington Hospital</b>			4b. City, Town, or Location of Death <b>Fort Washington</b>			4c. County of Death <b>Prince George's</b>			
Funeral Director	5. Social Security Number <b>577 56 0391</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>97</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>April 11, 1909</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b>			10b. County <b>Prince George's</b>			10c. City, Town or Location <b>Fort Washington</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>9311 Fort Foote Road</b>			10f. Zip Code <b>20744</b>			10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>XX</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Credit Clerk</b>			16b. Kind of Business/Industry <b>Retail</b>			
	17. Father's Name (First, Middle, Last) <b>Owen Thorne</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sadie Webster</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara Drake (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1301 Thornton Parkway, Fort Washington, MD 20744</b>					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Louis L. Frank m00257</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>			Date <b>Oct 2, 2006</b>	20c. Location - City or Town, State <b>Suitland, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Louis L. Frank m00257</b>					22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>acute myocardial infarction</b>								Approximate Interval Between Onset and Death <b>immediate</b>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Underlying cause unknown</b>								<b>years</b>	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>			28d. Describe how injury occurred				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D19781</b>			29d. Date signed (Month, Day, Year) <b>7/26/06</b>				
	29b. Signature and title of certifier <b>Frank M. Regan MD</b>		29e. Registrar's Signature <b>Leanne B. Spaulding</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frank M. Regan MD 11201 Langford Rd #103 Ft. Washington MD 20735</b>									
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature							

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30949

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

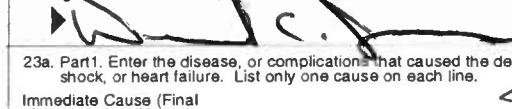
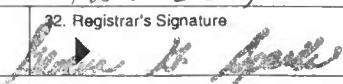
Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death			
Betty Jean Riddick		September 26 2006				4:40 A M			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death			
Washington Adventist Hospital		Tokoma Park				Montgomery			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
250-76-7513		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	62 Yrs.	Months	Days	Hours	Min.	11/26/1943	South Carolina
Usual Residence of Decedent									
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
Maryland	Prince George's	Springdale							
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?			
9632 Utica Place		20774				U.S.A.			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: Black		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:					
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Administrative Worker				New York Transit			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
James H. Peterson		Anna L. Thomas							
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
James J. Peterson / Son		8 Ensenada Court, Randallstown, Maryland 21133							
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)				Date	20c. Location - City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Rose Hills Cemetery				10/02/2006	Linden, New Jersey		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility							
		The Derrick C. Jones F/H, P.A.							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Due to (or as a consequence of): <i>Sepsis</i>				Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death)		23c. Due to (or as a consequence of): <i>Atherosclerotic Cardiovascular disease</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Due to (or as a consequence of): <i>Chronic renal failure</i>							
23e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23f. Date of delivery Month Day Year							
23g. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23h. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
23i. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		23j. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
23k. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		23l. Date of Injury (Month, Day, Year)		23m. Time of Injury		23n. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	23o. Describe how injury occurred		
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		M							
23p. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		23q. Location (Street and Number or Rural Route Number, City or Town, State)							
23r. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		23s. License number				23t. Date signed (Month, Day, Year)			
23u. Signature and title of certifier 		D0060100				09-26-06			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		831 UNIVERSITY BLVD SILVER SPRING, MARYLAND 20903							
TAHMINA K AHMED, MD									
31. Date filed (Month, Day, Year)		32. Registrar's Signature 							
SEP 29 2006									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30950

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL A. ROTH Sr.</b>							2. Date of Death Month Day Year <b>SEPTEMBER 26 2006</b>	3. Time of Death <b>4:00 P M</b>
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death		
Funeral Director	5. Social Security Number <b>219-34-1028</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>April 1, 1939</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Dundalk</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number <b>3432 Yardley Drive</b>			10f. Zip Code <b>21222</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1939</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business/Industry <b>Transportation</b>		
	17. Father's Name (First, Middle, Last) <b>Henry P. Roth</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Mallonee</b>			19a. Informant's Name/Relationship (Type, Print) <b>Linda Roth</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3432 Yardley Drive, Dundalk, Maryland 21222</b>
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Anthony Connelly</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>			Date <b>September 30, 2006</b>	20c. Location - City or Town, State <b>Dundalk, MD.</b>	
	21. Signature of Funeral Service Licensee			22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk, P.A.</b> <b>7110 Sollers Point Road, Dundalk, MD. 21222</b>					
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>RESPIRATORY FAILURE</b>								Approximate Interval Between Onset and Death
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>MULTILOBAR PNEUMONIA</b>								
	23c. If female: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23f. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>O. O. Falade M.D.</b>					
	29c. License number <b>RES 000</b>			29d. Date signed (Month, Day, Year) <b>SEPTEMBER 26, 2006</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>OLUWASEUN FALADE, JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b> <b>4940 EASTERN AVENUE, BALTIMORE, MD 21228</b>			31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>					
State Registrar	32. Registrar's Signature <b>[Signature]</b>			33. Date signed (Month, Day, Year) <b>SEPTEMBER 26, 2006</b>					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30951

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Helen Regula</i>			2. Date of Death Month Day Year September 27 2006	3. Time of Death 15:19 M
	4a. Facility Name (If not institution, give street and number) <i>The Johns Hopkins Hospital</i>			4b. City, Town, or Location of Death <i>Baltimore City</i>	4c. County of Death <i>Maryland</i>
Funeral Director	5. Social Security Number <i>212-12-6234</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>82 Yrs.</i>	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) <i>May 22, 1924</i>
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>Maryland</i> 10b. County <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>620 South Potomac Street</i>			10f. Zip Code <i>21224</i>	10g. Citizen of What Country? <i>U.S.A.</i>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>3</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <i>Homemaker</i>	16b. Kind of Business/Industry <i>Own Home</i>		
	17. Father's Name (First, Middle, Last) <i>Paul Regula, Sr.</i>	18. Mother's Name (First, Middle, Maiden Surname) <i>Victoria Doros</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Jo-Ann Hopkins (Niece)</i>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>310 George Avenue, Baltimore, Maryland 21221</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Sacred Heart of Mary</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Sacred Heart of Mary</i>	Date <i>Sept. 29, 2006</i>	20c. Location - City or Town, State <i>Baltimore, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>	22. Name and Address of Facility <i>Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221</i>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia			Approximate Interval Between Onset and Death <i>7 days</i>	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>	
	23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Johns Hopkins Hospital</i>			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Johns Hopkins Hospital</i>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>600 N. Wolfe Street, Baltimore, MD 21287</i>	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <i>RES-000</i>			
	29b. Signature and title of certifier <i>Terrence Brown MD</i>	29d. Date signed (Month, Day, Year) <i>September 27, 2006</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Terrence Brown MD</i>			31. Date filed (Month, Day, Year) <i>SEP 29 2006</i>	
				32. Registrar's Signature <i>[Signature]</i>	

Baltimore, Maryland 21215-0036

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Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30952

Reg. No.

1- For State Register		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
		OLGA RAYSINGER		SEPTEMBER 28 2006		1:00 AM	
Physician / Medical Examiner		4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director		5. Social Security Number 213 26 3473		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.	
				If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
						8. Date of Birth (Month, Day, Year) Oct. 11, 1930	
						9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Baltimore	
		10e. Street and Number 115 Bon Air Road		10f. Zip Code 21225		10g. Citizen of What Country? U.S.	
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Retail Management		16b. Kind of Business/Industry Department Store	
		17. Father's Name (First, Middle, Last) Charles Byron		18. Mother's Name (First, Middle, Maiden Surname) Olga Johnson			
		19a. Informant's Name/Relationship (Type, Print) Lois Krok / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8227 Sherbrooke Court Millersville, Maryland 21108			
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		Date 9/30/2006	20c. Location - City or Town, State Baltimore, Maryland
		21. Signature of Funeral Service Licensee ▶ RENO ALDRIDGE		22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225			
Physician / Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Due to (or as a consequence of): a. CARDIAC ARRHYTHMIA b. CONGESTIVE HEART FAILURE c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE d. CHRONIC KIDNEY DISEASE		Approximate Interval Between Onset and Death 7 DAYS YEARS YEARS YEARS	
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number RES001		29d. Date signed (Month, Day, Year) SEPTEMBER 28 2006	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAL DELMAN, 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225		32. Registrar's Signature ▶ TAL DELMAN			
		31. Date filed (Month, Day, Year) SEP 29 2006		33. Registrar's Signature ▶ TAL DELMAN			

Baltimore, Maryland 21215-0036

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

**AMENDED BY COURT** Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Item 1 per court order g973 3-15-16 vt

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No. 2006 30953

1- For State Registrar

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified.

1. Decedent's Name (First, Middle, Last)	So Soon Kim Song				2. Date of Death Month Day Year <b>Sep 26th 2006 16:55P</b>	3. Time of Death	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death <b>HOWARD</b>			
Howard County 5755 Cedar Columbia Md							
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>XX</b>	7. Age (in yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>JANUARY 26, 1912</b>		9. Birthplace (State or Foreign Country) <b>KOREA</b>	
Usual Residence of Decedent							
10a. State <b>MD</b>	10b. County <b>HOWARD</b>	10c. City, Town or Location <b>COLUMBIA</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>XX</b>	
10e. Street and Number <b>10717 HUNTING LANE</b>			10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <b>XX</b>	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>XX</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>XX</b>			14. Race - American Indian, Black, White, etc. Specify: <b>KOREAN</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 9</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) HOME MAKER</b>	16b. Kind of Business/Industry <b>OWN HOME</b>					
17. Father's Name (First, Middle, Last) <b>ICK BONG KIM</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>SAN CHUN LEE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SANG WON SONG SON</b>							
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>618 BELLFLOWER RD. LANGHORNE, PA. 19047</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>XX</b>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GEORGE WASHINGTON MEMORIAL PARK</b>	Date <b>OCT 2, 2006</b>	20c. Location - City or Town, State <b>PLYMOUTH MEETING, PA.</b>				
21. Signature of Funeral Service Licensee <b>K. GREGORY FINK</b>	22. Name and Address of Facility <b>FINK FUNERAL HOME, P.A. 426 CRAIN HWY S. GLEN BURNIE, MD. 21061</b>	Approximate Interval Between Onset and Death <b>few hours</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Hypovolemic Shock</b>							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Septic shock</b>							
a. Due to (or as a consequence of): <b>Hypovolemic Shock</b>							
b. Due to (or as a consequence of): <b>Septic shock</b>							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b>							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Leonel Barahona</b>		29c. License number <b>D 21928</b>		29d. Date signed (Month, Day, Year) <b>Sep/27th 2006</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LEONEL BARAHONA 3459 ST Johns Jane Elliott Rd 21042</b>							
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>							
32. Registrar's Signature <b>Leonele Barahona</b>							

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30954

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
ROBERT H. SHAW		SEPTEMBER 28, 2006				04:05AM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Saint Joseph Medical Center		Towson				Baltimore	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month Day Year Dec. 8, 1931	9. Birthplace (State or Foreign Country) Maryland
10a. State MD		10b. County Baltimore		10c. City, Town or Location Towson			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 8601 Pleasant Plains Road				10f. Zip Code 21286			10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supervisor			16b. Kind of Business/Industry Saft America Inc
17. Father's Name (First, Middle, Last) Harry Louis Shaw				18. Mother's Name (First, Middle, Maiden Surname) Allah Bryant			
19a. Informant's Name/Relationship (Type, Print) Dawn Hendley-daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2615 Long Meadow Drive-Abingdon, MD 21009			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 10-01-06	20c. Location - City or Town, State Parkville, Maryland		
21. Signature of Funeral Service Licensee <i>Condrie h M Feeder</i>				22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 Harford Road-Parkville, Maryland 21234			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Approximate Interval Between Onset and Death							
Immediate Cause (Final disease or condition resulting in death)							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p style="text-align: center;">ASYSTOLE</p> <p>a. Due to (or as a consequence of): MYOCARDIAL INFARCTION</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Khosrow Tabassi, M.D.</i>				29c. License number D46356			29d. Date signed (Month, Day, Year) September 28, 2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOSEW TABASSI, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204							
31. Date filed (Month, Day, Year) SEP 29 2006		32. Registrar's Signature <i>Dawn B. Feeder</i>					

ORIGINAL

## Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2006 30955

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1832 hrs
<b>Yuwadee R. Streett</b>		September 25, 2006

8152  
Funeral  
Director

4a Facility Name (if not institution, give street and number) <b>8527 Kings Ridge Road</b>	4b. City, Town, or Location of Death <b>Parkville</b>	4c. County of Death <b>Baltimore County</b>
---	--	--

5. Social Security Number <b>212-94-1002</b>	6. Sex <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65 Yrs</b>	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) <b>10/27/1940</b>	9. Birthplace (State or Foreign Country) <b>Thailand</b>
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10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Parkville</b>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
-------------------------	---------------------------------	---	---

10e. Street and Number <b>8527 Kings Ridge Rd.</b>	10f. Zip Code <b>21234</b>	10g. Citizen of What Country? <b>USA</b>
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11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: Specify <b>Asian</b>	14. Race - American Indian, Black, White, etc.
---	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>self employed</b>	16b. Kind of Business/Industry <b>seamstress</b>
--	---	---

17. Father's Name (First, Middle, Last) <b>Taison Reanrungroch</b>	18 Mother's Name (First, Middle, Maiden Surname) <b>Guateng Ang</b>
---	--

19a. Informant's Name/Relationship (Type, Print) <b>Matthew Streett - son</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6511 Brook Ave. Baltimore, MD 21206</b>
--	---

20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evans Funeral Chapel - Bel Air</b>	Date <b>September 27, 2006</b>	20c. Location - City or Town, State <b>Forest Hill, MD</b>
---	---	-----------------------------------	---

21. Signature of Funeral Service Licensee <i>Matthew Streett</i>	22. Name and Address of Facility <b>Evans Funeral Chapel 8800 Harford Rd. Parkville, MD 21234</b>
---	--

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
---	--

a. <b>Multiple injuries complicating hypertensive atherosclerotic cardiovascular disease</b> Due to (or as a consequence of):	
--	--

b.	Due to (or as a consequence of):
----	----------------------------------

c.	Due to (or as a consequence of):
----	----------------------------------

d.	
----	--

<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED item#23a,27,28a-f,perME,g860, 10/2/06 TT
--	---

IF FEMALE:	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
------------	---	---

23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
---	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
---	---	--

25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene	26. Place of Death (Check only one)
---	---	-------------------------------------

27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year) <b>Fnd 9/25/2006</b>	28b. Time of Injury <b>Fnd 6:26 pm</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>subject fell down steps</b>	28d. Describe how injury occurred
---	--	---	---	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>house</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>8527 Kings Ridge Rd. Parkville, MD</b>
---	---

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 26, 2006</b>
--	--	--

30. Name and address of person who completed cause of death (Item 23a) <b>Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>
--

31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>	32. Registrar's Signature <i>Matthew Streett</i>
---	---

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.   
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30956

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permits 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death	
<b>Henry Allison Smart, Jr.</b>					<b>September 27 2006</b>	<b>3:25P.M.</b>
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death	
<b>Baltimore Washington Medical Center</b>		<b>Glen Burnie</b>			<b>Anne Arundel</b>	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) Maryland
<b>218-76-0398</b>		<b>48</b>			<b>Sept 1, 1958</b>	
Usual Residence of Decedent						
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Maryland</b>	<b>Anne Arundel</b>	<b>Odenton</b>				
10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?	
<b>604 Old Waugh Chapel Road</b>			<b>21113</b>		<b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-employed</b>			16b. Kind of Business/Industry <b>Garden Center</b>	
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)		
<b>Henry Allison Smart, Sr.</b>				<b>Velma Dorothy Jane Bright</b>		
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Christina Marie Smart/daughter 1073 St. Stephens Church Road Crownsville, MD 21032</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>West Arundel Crematory</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date <b>10/2/2006</b>		20c. Location - City or Town, State <b>Odenton, Maryland</b>
21. Signature of Funeral Service Licensee <b>Quinton R Thomas</b>		22. Name and Address of Facility <b>Donaldson Funeral Home &amp; Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
<p>a. <b>Uncal Herniation</b> Due to (or as a consequence of):</p> <p>b. <b>Intra cranial hypertension</b> Due to (or as a consequence of):</p> <p>c. <b>Cerebrovascular embolism</b> Due to (or as a consequence of):</p> <p>d. _____</p>						
Approximate Interval Between Onset and Death						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <b>9/Unknown</b>			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial fibrillation</b>						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <b>Haria Jauia MD</b>		29c. License number <b>D0032744</b>		29d. Date signed (Month, Day, Year) <b>September 27, 2006</b>		
30. Name and address of person who completed cause of death (Item 23c. Type, Print) <b>Haria Jauia MD 301 Hospital Dr Glen Burnie MD 21061</b>						
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature <b>Stephanie L. Gaskins</b>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 2006 per ch 8860 10-10-06

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30957

For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month 09 Day 26 Year 06				3. Time of Death 2:32 A.M.			
Vernal H Smith								
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A			
Brittmore Rehabilitation Extended Care								
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) April 16, 1933	9. Birthplace (State or Foreign Country) Md		
216-30-5335								
10a. State Md						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10b. County N/A		10c. City, Town or Location Baltimore						
10e. Street and Number 5325 Lothian Road			10f. Zip Code 21212		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 24-5		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Improvement			16b. Kind of Business/Industry Self Employed		
17. Father's Name (First, Middle, Last) Vernal H Smith Sr.			18. Mother's Name (First, Middle, Maiden Surname) Roberta Garrett					
19a. Informant's Name/Relationship (Type, Print) Cila Raines Care Provider		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5325 Lothian Rd Baltimore Md 21212						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		Date 10/6/06	20c. Location - City or Town, State Baltimore			
21. Signature of Funeral Service Licensee Jerry Harris						22. Name and Address of Facility Chairman-Harris Funeral Home 5240 Reisterstown Rd Baltimore Md 21215		
a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death 10 months		
a. Due to (or as a consequence of): Carcinoma of Pancreas								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29c. License number 34359(0110)		
29b. Signature and title of certifier John S. Lehr, MD						29d. Date signed (Month, Day, Year) 9 26 2006		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John S. Lehr, MD 3900 Loch Raven Boulevard, Baltimore, Maryland 21208						32. Registrar's Signature John S. Lehr		
31. Date filed (Month, Day, Year) SEP 29 2006						33. Date signed (Month, Day, Year)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30958

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or if items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

Division of Vital Records, P.O. Box 68760,

State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>Harry Albert Sample</b>		2. Date of Death Month <b>09</b> Day <b>26</b> Year <b>2006</b>		3. Time of Death <b>11:44 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>		4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>218 26 1956</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>75 Yrs.</b>	If Under 1 Year Months      Days      Hours      Min.	
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Essex</b>		10d. Inside City Limits <b>1 Yes 2 No</b>
10e. Street and Number <b>2210 Silver Lane</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No If Yes, Give Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No      Specify: White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 5</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Operator</b>		16b. Kind of Business/Industry <b>Marine Repair</b>	
17. Father's Name (First, Middle, Last) <b>Harry Franklin Sample</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Margaret York</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Pamela Sue Wiegand (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2121 Silver Lane Baltimore, Maryland 21221</b>			
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>9/27/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>
21. Signature of Funeral Service Licensee <b>John W. Burkhardt</b>		22. Name and Address of Facility <b>Brudzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sepsis with multiorgan dysfunction syndrome</b>		23b. Due to (or as a consequence of): <b>a. Respiratory failure</b> Due to (or as a consequence of): <b>b. Pneumonia</b> Due to (or as a consequence of): <b>c. Acute renal failure</b>		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Anemia Prostate cancer CHF, TIA</b>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 Yes 2 No 9 Unknown</b>		23c. If yes, outcome of pregnancy <b>1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown</b>		23d. Date of delivery Month      Day      Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Anemia Prostate cancer CHF, TIA</b>		23e. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>			
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>		24a. Was an autopsy performed? <b>1 Yes 2 No</b>	
27. Manner of Death <b>1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day Year) <b>1 M</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <b>1 Yes 2 No</b>	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>9000 Franklin Square Drive Balto., MD 21237</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29c. License number <b>RES 00000</b>		29d. Date signed (Month, Day, Year) <b>9/26/06</b>	
29b. Signature and title of certifier <b>Dr. Hang Park</b>		32. Registrar's Signature <b>Reva S. Park</b>			
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature <b>Reva S. Park</b>			

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State of Maryland / Department of Health and Mental Hygiene  
1- For State Amend item#18, per H.G.859, 9/29/06 TT Certificate of Death Reg. No. 2006 30959  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Lewis Settle							2. Date of Death Month Day Year <b>SEPT 27 2006</b>	3. Time of Death 8:00 A M	
	4a. Facility Name (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death n/a		
Funeral Director	5. Social Security Number <b>230-44-7509</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	8. Date of Birth (Month Day Year) <b>07/13/1939</b>	9. Birthplace (State or Foreign Country) <b>VA</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b>				10b. County <b>n/a</b>	10c. City, Town or Location <b>Baltimore City</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2121 Allendale Road</b>				10f. Zip Code <b>21216</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supply Checker</b>		16b. Kind of Business/Industry <b>Sparrow Point</b>					
	17. Father's Name (First, Middle, Last) <b>Moses Settle</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha Miller</b>				<b>Bertha Millner</b>	
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Lucas / Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2121 Allendale Road; Baltimore, MD 21216</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Jones</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>09/30/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
	21. Signature of Funeral Service Licensee <b>Jones</b>				22. Name and Address of Facility <b>Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 21217</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>PNEUMONIA</b>								Approximate Interval Between Onset and Death <b>Few days</b>	
	b. Substantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Metastatic lung Cancer</b>								Approximate Interval Between Onset and Death <b>Few months</b>	
	c. Due to (or as a consequence of): <b>HIV</b>				d.					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HIV</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>8/27/06</b>		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D0062634</b>				29d. Date signed (Month, Day, Year) <b>9/27/06</b>	
	29b. Signature and title of certifier <b>MA TEEN AWAN</b>				29e. Registrar's Signature <b>Regina B. Jones</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MA TEEN AWAN 10802 HICKORY RIDGE RD COLUMBIA MD 21044</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 5 per fb 8859 9-29-06 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30960

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death			
PAMELA SLESICKI	SEPT 22 2006	10:30 PM			
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE	N/A			
5. Social Security Number	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 19, 1966	9. Birthplace (State or Foreign Country) JAPAN

Funeral  
Director

To Be Completed by Funeral Director

10a. State MD.	10b. County N/A	10c. City, Town or Location BALTIMORE	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 1628 THAMES STREET		10f. Zip Code 21231	10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) EXECUTIVE	16b. Kind of Business/Industry SATELLITE T.V.	

17. Father's Name (First, Middle, Last) RAYMOND LEON SLESICKI	18. Mother's Name (First, Middle, Maiden Surname) NORIKO ANGELA ISE
19a. Informant's Name/Relationship (Type, Print) RAYMOND SLESICKI / FATHER	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2257 ZINFANDEL DRIVE, RANCHO CORDOVA, CA 95670

20a. Method of Disposition  
1  Burial 2  Cremation 3  Removal from State  
4  Donation 5  Other (Specify)  
BAYVIEW CREMATORY 9/28/06

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Date  
20c. Location - City or Town, State  
BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

LILY & ZEILER INC. FUNERAL HOME  
1901 EASTERN AVENUE, BALTIMORE, MD. 21231

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death 1 WEEK
a. RESPIRATORY DEPRESSION (FROM HEPATIC ENCEPHALOPATHY)	
b. END STAGE LIVER DISEASE (ALCOHOLIC HEPATITIS)	5 YEARS
c. Due to (or as a consequence of): d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE (HEPATOURENAL SYNDROME)	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
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25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number RES-000	29d. Date signed (Month, Day, Year) SEPT 22, 2006
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EMMANUEL ANTONARAKIS, 4940 EASTERN AVENUE, BALTIMORE, MD	31. Date filed (Month, Day, Year) SEP 29 2006	32. Registrar's Signature James K. Bratton
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Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene  
Important: If Item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transcript.

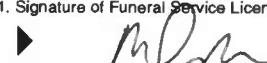
Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30961  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kamilla Toth</b>							2. Date of Death Month <b>9</b> Day <b>28</b> Year <b>06</b>	3. Time of Death <b>0545</b>
	4a Facility Name (If not institution, give street and number) <b>10401 Kingsbridge Rd</b>							4b. City, Town, or Location of Death <b>Ellicott City</b>	4c. County of Death <b>Howard</b>
Funeral Director	5. Social Security Number <b>N/A</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>6-2-1929</b>	9. Birthplace (State or Foreign Country) <b>Hungary</b>		
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>10401 Kingsbridge road</b>		10f. Zip Code <b>21042</b>					10g. Citizen of What Country? <b>Hungary</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Elementary/Secondary (0-12) 12</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) <b>College (1-4 or 5+)</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-Employed</b>			16b. Kind of Business/Industry <b>Sales</b>				
17. Father's Name (First, Middle, Last) <b>Istvan Kovacs</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Margit Morva</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lea Lazar Rogers- daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10401 Kingsbridge Rd, Ellicott City, MD 21042</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Metro Crematory</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>			Date	20c. Location - City or Town, State <b>9/29/2006 Catonsville, MD</b>			
21. Signature of Funeral Service Licensee 									
22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)  a. <b>Pulmonary Embolism</b> Due to (or as a consequence of):  b. <b>Left leg Deep Venous Thrombosis</b> Due to (or as a consequence of):  c. <b>Stage Four Lung Cancer</b> Due to (or as a consequence of):  d. _____									
Approximate Interval Between Onset and Death  3 days  9 months									
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  Paul D. Rogers MD 10401 Kingsbridge Rd Ellicott City MD 21042							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)		29c. License number <b>D0037185</b>							
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		29d. Date signed (Month, Day, Year) <b>9-28-2006</b>							
32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or item 23a or 23e is marked other than "natural", or if item 27 is marked other than "natural", or if item 23a or 23e is marked other than "natural", the Medical Examiner must be notified.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 3 per M.H. 600, 10/11/00dhp  
Certificate of Death

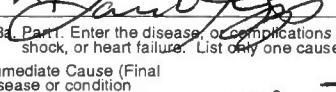
2006 30962  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carol Shipley Thamert</b>				2. Date of Death Month Day Year <b>09 25 2006</b>	3. Time of Death M <b>10:30am</b>			
	4a. Facility Name (If not institution, give street and number) <b>The Pines-Genesis Healthcare</b>		4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>				
Funeral Director	5. Social Security Number <b>216 217-72-9608</b>	6. Sex <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>	7. Age (In yrs. last birthday) <b>48 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>SEP 11, 1958</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Royal Oak</b>		10d. Inside City Limits <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		
To Be Completed by Funeral Director	10e. Street and Number <b>3965 Bellevue Road</b>			10f. Zip Code <b>21162</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> If Yes, Give Year or Dates: <b>X</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> Specify: <b>White</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 2 Registered Nurse</b>		16b. Kind of Business/Industry <b>University of Maryland Shock Trauma Unit</b>				
	17. Father's Name (First, Middle, Last) <b>Thomas Shipley</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Barbara Parks</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>John B. Thamert - husband</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3965 Bellevue Road Royal Oak, MD 21162</b>					
	20a. Method of Disposition <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Memorial Gardens</b>		Date <b>9/29/06</b>	20c. Location - City or Town, State <b>Finksburg, MD</b>			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <b>David T. McDonald</b>		22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, MD 21784 (410) 795-1400</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Encephalopathy</b> months Due to (or as a consequence of):  b. <b>Anemia of chronic disease</b> months Due to (or as a consequence of):  c. <b>Severe immunodeficiency syndrome</b> years Due to (or as a consequence of):  d. <b>Human immunodeficiency virus</b> years								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>		23c. If yes, outcome of pregnancy <b>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown</b>		23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>				
	25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>		26. Place of Death (Check only one) Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>		24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>			24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	
	27. Manner of Death <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>	28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>	28d. Describe how injury occurred				
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>610 Dutchmans Lane, Easton, MD 21601</b>				
	29a. Certifier (Check only one) <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29c. License number <b>D25933</b>		29d. Date signed (Month, Day, Year) <b>9/25/06</b>				
	29b. Signature and title of certifier <b>David T. McDonald</b>		32. Registrar's Signature <b>Karen B. Geller</b>		31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>				

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene  
Amend item#23a-c,perMD,g859,9/29/06 II  
1- For State Registrar Certificate of Death 2006 30963  
Reg. No.

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>MARY VARTERESIAN</b>						2. Date of Death Month <b>SEPT</b> Day <b>24</b> Year <b>2006</b>	3. Time of Death <b>535 AM</b>					
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>			4b. City, Town, or Location of Death <b>Columbia</b>			4c. County of Death <b>Howard</b>						
To Be Completed by Funeral Director		5. Social Security Number <b>035-14-5297</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>05/20/1923</b>	9. Birthplace (State or Foreign Country) <b>RI</b>					
		Usual Residence of Decedent 10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
		10e. Street and Number <b>6242 Deep Earth Lane</b>			10f. Zip Code <b>21045</b>			10g. Citizen of What Country? <b>USA</b>						
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates: <input checked="" type="checkbox"/>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <input checked="" type="checkbox"/> White			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry <b>Own Home</b>						
		17. Father's Name (First, Middle, Last) <b>John Nahigian</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rebecca Minasian</b>									
		19a. Informant's Name/Relationship (Type, Print) <b>Lynne Karanfil / Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6242 Deep Earth Lane, Columbia, MD 21045</b>									
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park, Elkridge, MD</b>		Date <b>09/26/2006</b>	20c. Location - City or Town, State <b>Elkridge, MD</b>							
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075</b>										
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b>						Approximate Interval Between Onset and Death <b>3 Days</b>						
		a. <b>Pneumonia</b> Due to (or as a consequence of):												
		b. <b>Sepsis</b> Due to (or as a consequence of):						3 Days						
		c. <b>Atherosclerosis</b> Due to (or as a consequence of):						years						
		d.												
Physician /Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check one: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <b>10/24/2006</b>		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
								28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Columbia, MD 21045</b>			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 			29c. License number <b>251060</b>		29d. Date signed (Month, Day, Year) <b>SEPT 24, 2006</b>	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JONATHAN FISH NO 10700 CHAREN DR #200 COLUMBIA, MD 21045</b>												
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial and

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

## To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
amend item 16b per th 859 9-29-06 vt

State of Maryland / Department of Health and Mental Hygiene 2006 30964

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CELIA VOLEN</b>						2. Date of Death Month Day Year <b>SEPT. 24, 2006</b>	3. Time of Death 7:25 P M			
	4a. Facility Name (If not institution, give street and number) <b>7000 KIMMEL ROAD</b>			4b. City, Town, or Location of Death <b>MT. AIRY</b>			4c. County of Death <b>FREDERICK</b>				
Funeral Director	5. Social Security Number <b>157-09-5367</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>09/20/1920</b>	9. Birthplace (State or Foreign Country) <b>NEW JERSEY</b>				
Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>FREDERICK</b> 10c. City, Town or Location <b>MT. AIRY</b> 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
10e. Street and Number <b>12602 KNOLL ROAD</b>				10f. Zip Code <b>21771</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: <b>WHITE</b>			14. Race - American Indian, Black, White, etc.			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>			16b. Kind of Business/Industry <b>MEDICAL</b>			<b>MEDICAL</b>			
17. Father's Name (First, Middle, Last) <b>BENJAMIN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HOROWITZ CLAIRE</b>			19a. Informant's Name/Relationship (Type, Print) <b>MICHAEL VOLEN / SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12602 KNOLL ROAD - MT. AIRY, MD 21771</b>	
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>JUDEAN MEMORIAL GARDENS</b>			Date <b>09/28/2006</b>	20c. Location - City or Town, State <b>OLNEY, MD</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b>			8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { a. <i>Disease of left foot</i> Due to (or as a consequence of): b. <i>Anterior tibial artery occlusion</i> Due to (or as a consequence of): c. <i></i> Due to (or as a consequence of): d. <i></i>									Approximate Interval Between Onset and Death <b>1 week</b>		
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown									23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)	23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Multi-infarct dementia</i> <i>Atrial fibrillation</i>									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Hospital</i>		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined									28a. Date of Injury (Month, Day Year) <b>M</b> 28b. Time of Injury <b>M</b> 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier 	29c. License number <b>030496</b>	29d. Date signed (Month, Day, Year) <b>9/28/2006</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Francis L. Becker MD 300 W. 9th St, Frederick, MD 21701</i>									31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>	32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached (or use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene 2006 30965  
*Certificate of Death* Reg. No.

giene 2006 30965  
Req. No.

**Req. No.**

**Baltimore, Maryland 21215-0036**

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Robert John Weaver, Sr.</b>							2. Date of Death Month Day Year <b>September 27 2006</b>	3. Time of Death <b>12:30 a m</b>			
	4a. Facility Name (If not institution, give street and number) <b>Genesis Heritage Nursing Center</b>				4b. City, Town, or Location of Death <b>Dundalk</b>			4c. County of Death <b>Baltimore</b>				
<b>Funeral Director</b>	5. Social Security Number <b>212-36-0203</b>		6. Sex <b>1 ♂ M 2 ♀ F</b>	7. Age (In yrs. last birthday) <b>69 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>FEB 26 1937</b>	9. Birthplace (State or Foreign Country) <b>MD</b>				
	10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>				10d. Inside City Limits <b>1 ⚡ Yes 2 ☐ No</b>			
<b>To Be Completed by Funeral Director</b>	10e. Street and Number <b>7816 E Collingham Drive</b>				10f. Zip Code <b>21222</b>			10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <b>1 ⚡ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 ☐ Yes 2 ⚡ No If Yes, Give Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 ☐ Yes 2 ⚡ No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: white</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) Mill Wright</b>			16b. Kind of Business/Industry <b>Sparrows Point</b>							
17. Father's Name (First, Middle, Last) <b>James Weaver</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Eleanor A. Weber</b>							
19a. Informant's Name/Relationship (Type, Print) <b>David Weaver - son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2211 Heandland Blvd., Sparrows Point, MD 21219</b>							
20a. Method of Disposition <b>1 ☐ Burial 2 ⚡ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>				Date <b>9/29/2006</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21286</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death)		<b>CARCINOMA OF LUNG 24 YEARS</b>										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE 12 YEARS</b>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <b>1 ☐ Yes 2 ☐ No 9 ☐ Unknown</b>		23c. If yes, outcome of pregnancy <b>1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown</b>					23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23e. Did tobacco use contribute to the cause of death? <b>1 ⚡ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown</b>	
25. Was case referred to medical examiner? <b>1 ☐ Yes 2 ⚡ No</b>		26. Place of Death (Check only one) <b>Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)</b>										
27. Manner of Death <b>1 ⚡ Natural 5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide</b>		28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		28c. Injury at Work? <b>1 ☐ Yes 2 ☐ No</b>		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <b>1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29b. Signature and title of certifier 									29c. License number <b>D14160</b>	
											29d. Date signed (Month, Day, Year) <b>SEPTEMBER 27, 2006</b>	
30. Name and Address of person who completed cause of death (Item 13a, Type, Print) <b>HARJIT SINGH M.D. 510 A RITCHIE HIGHWAY, BALTIMORE, MARYLAND 21225.</b>												
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature 										
6												
State Registrar												

Division of Vital Records, P.O. Box 688760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**Baltimore, Maryland 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, it is Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner**

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30966

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at:

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Christine Lee Weitzel</b>		2. Date of Death Month <b>September</b> Day <b>24</b> Year <b>2006</b>		3. Time of Death 8:13p M
4a. Facility Name (If not institution, give street and number) <b>6117 Old Washington Road</b>		4b. City, Town, or Location of Death <b>Sykesville</b>		4c. County of Death <b>Carroll</b>
5. Social Security Number <b>213-52-6081</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months      Days      Hours      Min.
10a. State <b>Md</b>		10b. County <b>Carroll</b>	10c. City, Town or Location <b>Sykesville</b>	
10e. Street and Number <b>6117 Old Washington Road</b>		10f. Zip Code <b>21784</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>X</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      Specify: <b>X</b>	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>	16b. Kind of Business/Industry <b>domestic</b>	
17. Father's Name (First, Middle, Last) <b>William Nelson Spence</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Lee Gallion</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Amy C. Huey (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5517 Strawbridge Terrace, Eldersburg, MD 21784</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Daniel McDonald MO0848</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Memorial</b>	Date <b>9/29/06</b>	20c. Location - City or Town, State <b>Sykesville, MD</b>
21. Signature of Funeral Service Licensee <b>► Daniel McDonald MO0848</b>		22. Name and Address of Facility Haight Funeral Home & Chapel <b>P.O. Box 195 Sykesville, MD 21784</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <b>6 months</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
a. <b>lung cancer</b> Due to (or as a consequence of):				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month      Day      Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
29b. Signature and title of certifier <b>► Rosalyn Juergens</b>		29c. License number <b>D60203</b>		29d. Date signed (Month, Day, Year) <b>September 25, 2006</b>
30. Name and address of person completing use of death (Item 23a) (Type, Print) <b>Rosalyn Juergens</b>		21231		
31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature <b>► [Signature]</b>		

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30967  
Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARIE HARRIETT WITSIK</b>							2. Date of Death Month Day Year <b>September 26, 2006</b>	3. Time of Death <b>5:10 P.M.</b>				
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Center</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>						
Funeral Director	5. Social Security Number <b>147-18-5434</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 5, 1925</b>	9. Birthplace (State or Foreign Country) <b>New Jersey</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>1110 Washingtonville Drive</b>				10f. Zip Code <b>21210</b>			10g. Citizen of What Country? <b>U.S.A.</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1948</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 years</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>								
	17. Father's Name (First, Middle, Last) <b>Peter MacDonald</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katie MacDougal</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>William Witsik (son)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1110 Washingtonville Drive Baltimore, Maryland 21210</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>George J. Ferraro</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Machpelah Cemetery</b>		Date <b>9-30-06</b>	20c. Location - City or Town, State <b>North Bergen, New Jersey</b>						
	21. Signature of Funeral Service Licensee <b>George J. Ferraro</b>			22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Lung Cancer</b> Approximate Interval Between Onset and Death <b>months</b>												
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>												
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) <b>Sept 29 2006</b>		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Hospitalized</b>
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>								28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6601 N Charles St Baltimore MD 21204</b>				
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29c. License number <b>D 58303</b>		29d. Date signed (Month, Day, Year) <b>September 26 2006</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AMON J. CHARLES</b>								31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>				

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30968

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian F. Wojcik</b>						2. Date of Death Month Day Year <b>September 24, 2006</b>	3. Time of Death <b>12:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Riverview Nursing Home</b>			4b. City, Town, or Location of Death <b>Essex</b>			4c. County of Death <b>Baltimore Co.</b>		
Funeral Director	5. Social Security Number <b>214-05-3817</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 19, 1920</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Dundalk</b>	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>702 Oakleigh Beach Road</b>			10f. Zip Code <b>21222</b>			10g. Citizen of What Country? <b>United States</b>		
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>8 Years</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8 Years</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Anthony Roman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Stella Dembowski</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Son In Law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>702 Oakleigh Beach Road Dundalk, Maryland 21222</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Holy Rosary Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery</b>		Date <b>9/28/2006</b>	20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>D. C. Call</b>		22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>						
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Hypertension</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Anemia</b> <b>Dementia</b> <b>Congestive Heart failure</b>								
	Approximate Interval Between Onset and Death								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <b>Other (Specify)</b>			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aortic Stenosis</b>								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Sebastian John 3023 Eastern Avenue Baltimore MD 21224</b>					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <b>Sebastian John</b>								
	29c. License number <b>00055171</b>								
	29d. Date signed (Month, Day, Year) <b>9/25/06</b>								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sebastian John 3023 Eastern Avenue Baltimore MD 21224</b>								
	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>		32. Registrar's Signature <b>John J. [Signature]</b>						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

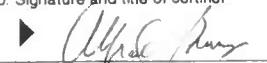
2006

30969

1- For  
State  
Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Feliciiana D. Ariola</b>					2. Date of Death Month Day Year <b>September 13, 2006</b>	3. Time of Death <b>8:43 A M</b>	
	4a. Facility Name (If not institution, give street and number) <b>Ft. Washington Hospital</b>			4b. City, Town, or Location of Death <b>Ft. Washington</b>		4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>579-94-8635</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Jan. 24, 1920</b>	9. Birthplace (State or Foreign Country) <b>Philippines</b>	
	Usual Residence of Decedent 10a. State <b>Maryland</b>			10b. County <b>Prince George's</b>			10c. City, Town or Location <b>Ft. Washington</b>	
10e. Street and Number <b>13206 Bangor Drive</b>				10f. Zip Code <b>20744</b>			10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: Filipino</b>			14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>In Home</b>		
17. Father's Name (First, Middle, Last) <b>Marcelo Ariola</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Damasa Domingo</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Matilde Antonio / Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13206 Bangor Drive Ft. Washington, Maryland 20744</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>St. Mary's Church Cem.</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's Church Cem.</b>			Date <b>09/23/2006</b>	20c. Location - City or Town, State <b>Clinton, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>George P. Kalas Funeral Home P.A.</b> <b>6160 Oxon Hill Road Oxon Hill, Maryland 20745</b>				
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>CHIROPALMOPATHY ARREST</b> Due to (or as a consequence of):</p> <p>b. <b>ISCHEMIC heart disease</b> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death <b>15 years</b></p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><b>ACUTE NEUROMA</b></p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p>								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
29b. Signature and title of certifier 		29c. License number <b>12300 DC</b>			29d. Date signed (Month, Day, Year) <b>9/13/06</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alfred C. Burns 11701 Liverton St. Friends rd</b>								
31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CR (5)

**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

2006 30970

**1. For State Registrar**

1. Decedent's Name (First, Middle, Last) <b>Mary Ann Bransky</b>				2. Date of Death Month <b>September</b> Day <b>12</b> , Year <b>2006</b>	3. Time of Death 1725 hrs
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**Physician/  
Medical Examiner****Funeral Director****To Be Completed by Funeral Director**

Baltimore, MD 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
 Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
 injury or other traumatic event, the Medical Examiner must be notified at once.

4a. Facility Name (if not institution, give street and number) <b>Doctor's Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>	4c. County of Death <b>Prince George's</b>
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5. Social Security Number <b>160-20-7619</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b>	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (MM/DD/YYYY) <b>May 20, 1927</b>	9. Birthplace (State or Foreign) <b>Pennsylvania</b>
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10a. State <b>Maryland</b>				10b. County <b>Prince George's</b>	10c. City, Town or Location <b>Greenbelt</b>	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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10e. Street and Number <b>5 Greendale Place</b>			10f. Zip Code <b>20770</b>	10g. Citizen of What Country? <b>United States</b>
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	16b. Kind of Business/Industry <b>own home</b>
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17. Father's Name (First, Middle, Last) <b>Joseph Castagnola</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Lemmo</b>
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19a. Informant's Name/Relationship (Type, Print) <b>Patricia A. Magill -daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Greenway Place Greenbelt, Maryland 20770</b>
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Donald V. Borgwardt</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>	Date <b>9/18/2006</b>	20c. Location - City or Town, State <b>Silver Spring, Maryland</b>
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21. Signature of Funeral Service Licensee <i>Donald V. Borgwardt</i>	22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705</b>
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a Chest Injuries Complicating Atherosclerotic Cardiovascular Disease</b>			Approximate Interval Between Onset and Death
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Due to (or as a consequence of): b. <b>b. Due to (or as a consequence of):</b>			
--	--	--	--

c. <b>c. Due to (or as a consequence of):</b>			
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d. <b>d.</b>			
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<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year
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23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) <b>FOUND: Sep 12, 2006</b>	28b. Time of Injury <b>FOUND: 1540 hrs</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <b>Driver auto fixed object collision</b>
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Local Street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>125 Hillside Road, Greenbelt, MD</b>
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29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated	29c. License number <b>O.C.M.E.</b>	29d. Date signed (Month, Day, Year) <b>September 13, 2006</b>
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29b. Signature and title of certifier <i>Theodore M. King, Jr., MD.</i>
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30. Name and address of person who completed cause of death (Item 23a) <b>Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201</b>
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31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>	32. Registrar's Signature <i>James B. Apold</i>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30971

Reg. No.

1 - For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Digna Arabela Berrios</b>							2. Date of Death Month Day Year September 12, 2006	3. Time of Death 11:45 AM	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery Hospice - Casey House</b>			4b. City, Town, or Location of Death <b>Rockville</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>577-72-1747</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>March 30, 1929</b>	9. Birthplace (State or Foreign Country) <b>E1 Salvador</b>	
	Usual Residence of Decedent 10a. State <b>Maryland</b>								10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Poolesville</b>
10e. Street and Number <b>17107 Campbell Farm Road</b>				10f. Zip Code <b>20837</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>E1 Salvadorian</b>				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Utility Worker</b>				16b. Kind of Business/Industry <b>Kennedy Center</b>		
17. Father's Name (First, Middle, Last) <b>Heriberto Ventura</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Maria Turcios</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Flor M. Cascio/Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17107 Campbell Farm Road, Poolesville, Maryland 20837</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>Maryland Memorial National Cemetery</b>		Date <b>9/16/2006</b>	20c. Location - City or Town, State <b>Laurel, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Nancy A. Pacentie</b>					22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Avenue, Silver Spring, Maryland 20904</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
<p>a. <b>Septicemia</b> Due to (or as a consequence of):</p> <p>b. <b>Gangrene Right Leg</b> Due to (or as a consequence of):</p> <p>c. <b>Arterial Thromboembolism Right Leg</b> Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
<p>Vascular Dementia</p> <p>Atrial Fibrillation</p>										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Cynthia M. Williams, D.O.</b>					29c. License number <b>H0058032</b>			29d. Date signed (Month, Day, Year) <b>Sept. 12, 2006</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Cynthia M. Williams, D.O., Montgomery Hospice, 6001 Muncaster Mill Road, Rockville, Maryland 20855</b>										
31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>		32. Registrar's Signature <b>Laura B. Apelt</b>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury, or other traumatic event, the Medical Examiner must be notified at once.

06-07097

Walter Avetta Castro

**Please Type or Print in Black Indelible Ink  
and Item 7, 8, per ME, g860, 10/17/06**

State of Maryland Department of Health and Mental Hygiene

**Certificate of Death**

Reg. No.

2006 30972

**1- For State Registrar**

1. Decedent's Name (First, Middle, Last)

Walter Edgardo Herrera Castro

2 Date of Death

Month

Day

Year

September 19, 2006

3 Time of Death

1838 hrs

**Physician/  
Medical Examiner****Funeral  
Director****To Be Completed by Funeral Director**

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/  
Medical Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached from us, as the burial - transit

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death

To the Funeral Director: After this certificate has been signed by the attending physician and

completely filled in by the funeral director, page 2 should be detached from us, as the burial - transit

4e Facility Name (if not institution, give street and number)

Southern Maryland Hospital

4b City, Town, or Location of Death

Clinton

4c County of Death

Prince George's

5. Social Security Number

None

6. Sex

 M F

7. Age (In yrs. last birthday)

23

24

Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

09

16

1982

05/18/1983

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

 Yes  No

10e. Street and Number

2414 Evans Parkway

10f. Zip Code

20902

10g. Citizen of What Country?

El Salvador

11. Marital Status

1  Never Married 2  Married3  Widowed4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No specify:

Salvadorian

14. Race - American Indian, Black, White, etc.

White

Specify:

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

College (1-4 or 5+)

Utility Worker

16b. Kind of Business/Industry

Private

Construction

17. Father's Name (First, Middle, Last)

Douglas Herrera

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Castro

19a. Informant's Name/Relationship (Type, Print)

Maria Guadalupe Herrera (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2414 Evans Parkway, Silver Spring, MD 20902

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State4  Donation 5  Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gat of Heaven Cem.

Date

9/25/06

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22 Name and Address of Facility

Rendon Hale Funeral Home

9013 Annapolis Road, Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Environmental asphyxia complicated by drowning

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED item#23a,27,28a-f,perME,g860, 10/17/06 TT item#, perME

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy4  Pregnant at time of death 5  Other (Specify)9  Unknown

23d. Date of delivery

Month Day Year

25. Was case referred to medical examiner?

1  Yes 2  No

26. Place of Death (Check only one)

Hospital: 1  Inpatient 2  ER/Outpatient 3  DOAOther: 4  Nursing Home 5  Residence 6  Other

27. Manner of Death

1  Natural5  Pending Investigation2  Accident6  Could not be determined3  Suicide7  Homicide

28a. Date of Injury (Month, Day, Year)

9/19/2006

28b. Time of Injury

Fnd 1:41 pm

28c. Injury at Work?

1  Yes 2  No

28d. Describe how injury occurred

subject asphyxiated due to low environmental oxygen

28e. Place of Injury - At home, farm, street, factory, office building, etc

(Specify) street (underground)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 10301 Marlboro Pike Upper Marlboro, MD

29a. Certifier

1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

one)

2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of Certifier

*[Signature]*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 20, 2006

30. Name and address of person who completed cause of death (Item 23a)

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

SEP 22 2006

32. Registrar's Signature

*[Signature]*

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

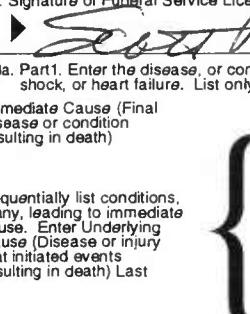
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30973

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sally Lou CAUDILL</b>							2. Date of Death Month Day Year <b>September 16 2006</b>	3. Time of Death 0220 AM				
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>			4b. City, Town, or Location of Death <b>Hagerstown</b>			4c. County of Death <b>Washington</b>						
Funeral Director	5. Social Security Number <b>279-32-0266</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70 Yrs.</b>	If Under 1 Year Months Days Hours Min. 	If Under 24 Hrs. 	8. Date of Birth (Month, Day, Year) <b>May 22, 1936</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Washington</b> 10c. City, Town or Location <b>Maugansville</b>									10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>13929 Maugansville Road</b>			10f. Zip Code <b>21767</b>			10g. Citizen of What Country? <b>USA</b>						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+) 0 homemaker</b>			16b. Kind of Business/Industry <b>her own home</b>						
	17. Father's Name (First, Middle, Last) <b>Everett Knapp</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marcella Bloss</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Herman T. Caudill - husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13929 Maugansville Rd., Maugansville, Md. 21767</b>								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rocky Gap Vet.Cem.</b>			Date <b>9/19/06</b>	20c. Location - City or Town, State <b>Flintstone, Md.</b>					
	21. Signature of Funeral Service Licensee 												
Physician /Medical Examiner	22. Name and Address of Facility <b>MINNICH FUNERAL HOME 115 E. Wilson Blvd., Hagerstown, Md. 21740</b>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ANOXIC ENCEPHALOPATHY</b> Due to (or as a consequence of): <b>AUTOCEREBROVASCULAR INFARCT</b> Due to (or as a consequence of): <b>AUTOCARDIAC INFARCTION</b> Due to (or as a consequence of): 									Approximate Interval Between Onset and Death			
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier 			
	29c. License number <b>D62562</b>									29d. Date signed (Month, Day, Year) <b>09.16.06</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MADHAVI HUBBY WASHINGTON COUNTY HOSPITAL 251 CANTON ST HAGERSTOWN MD 21740</b>												
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 19 2006</b>	32. Registrar's Signature 											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30974

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ethel Frazier Cornwell</b>					2. Date of Death Month Day Year <b>September 14, 2006</b>	3. Time of Death 0225 A M		
	4a. Facility Name (If not institution, give street and number) <b>Kline Hospice House</b>			4b. City, Town, or Location of Death <b>Mt. Airy</b>		4c. County of Death <b>Frederick</b>			
Funeral Director	5. Social Security Number <b>577-36-1831</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>June 12, 1924</b>	9. Birthplace (State or Foreign Country) <b>Tennessee</b>		
	10a. State <b>MD</b>			10b. County <b>Frederick</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>537 Carrollton Street</b>			10f. Zip Code <b>21701</b>			10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>If Yes, Give Year or Dates:</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>5+</b> <b>Professor</b>			16b. Kind of Business/Industry <b>Education</b>			
17. Father's Name (First, Middle, Last) <b>Robert Thomas Frazier</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Thompson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Raymond F. Cornwell/son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>608 S. Dorcas Rd. Holland, OH 43528</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Beverly L. Heckrotte</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>			Date <b>09/18/06</b>	20c. Location - City or Town, State <b>Beltsville, MD</b>		
21. Signature of Funeral Service Licensee <b>Beverly L. Heckrotte</b>				22. Name and Address of Facility <b>Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): <b>Breast Cancer</b>				Approximate Interval Between Onset and Death <b>3 years</b>	
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
23d. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Kanan Hudhud, MD</b>		29c. License number <b>DY1866</b>				29d. Date signed (Month, Day, Year) <b>September 14, 2006</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kanan Hudhud, MD 46B Thomas Johnson Drive Frederick, MD 21702</b>									
31. Date filed (Month, Day, Year) <b>SEP 18 2006</b>		32. Registrar's Signature <b>Karen G. Frazier</b>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30975

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Fay Helene DWORKIN</b>						2. Date of Death Month <b>September</b> Day <b>13</b> , Year <b>2006</b>	3. Time of Death <b>9:25 P M</b>			
	4a. Facility Name (If not institution, give street and number) <b>3723 Astoria Road</b>			4b. City, Town, or Location of Death <b>Kensington</b>			4c. County of Death <b>Montgomery</b>				
Funeral Director	5. Social Security Number <b>121-26-1406</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Dec. 21, 1934</b>	9. Birthplace (State or Foreign Country) <b>New York</b>			
	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Kensington</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>3723 Astoria Road</b>			10f. Zip Code <b>20895</b>			10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>white</b>			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)      College (1-4 or 5+) <b>5+</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Economist</b>			16b. Kind of Business/Industry <b>US Government</b>				
	17. Father's Name (First, Middle, Last) <b>Charles Zuker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Mitchell</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Morris Dworkin, Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>517 Bradford Drive, Rockville, MD 20850</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Memorial Gardens</b>		Date <b>09/18/06</b>	20c. Location - City or Town, State <b>Olney, MD</b>				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Torchinsky Hebrew Funeral Home</b> <b>254 Carroll St., NW, Washington, DC 20012</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Renal Failure</b>								Approximate Interval Between Onset and Death <b>2 months</b>		
	b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Multiple Myeloma</b>								15 months		
	c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe Anemia</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	27. Manner of Death <b>1 Natural</b> <b>5 Pending investigation</b> <b>2 Accident</b> <b>6 Could not be determined</b>			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <b>1 Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2 Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <b>D 35996</b>						29d. Date signed (Month, Day, Year) <b>September 14, 2006</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Linda M. Burrell, M.D., 2730 University Blvd., W., #400, Wheaton, MD 20902</b>								31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>		32. Registrar's Signature 

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner will be notified all times.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

20

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Amend Items 29c,d,30 per dr., G859,09/29/06 th Certificate of Death  
Reg. No. 2006 30976

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Virginia Evans</b>							2. Date of Death Month 09 Day 10 Year 2006	3. Time of Death 6:55A M			
	4a. Facility Name (If not institution, give street and number) <b>Garrett County Mem'l Hospital</b>			4b. City, Town, or Location of Death <b>Oakland</b>			4c. County of Death <b>Garrett</b>					
Funeral Director	5. Social Security Number <b>234-68-9333</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) <b>06/15/1923</b>	9. Birthplace (State or Foreign Country) <b>WV</b>					
	Usual Residence of Decedent 10a. State <b>WV</b> 10b. County <b>Preston</b> 10c. City, Town or Location <b>Horse Shoe Run</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
To Be Completed by Funeral Director	10e. Street and Number <b>Rural Route 1 Box 281</b>			10f. Zip Code <b>26716</b>			10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Book Keeper</b>		16b. Kind of Business/Industry <b>Service Station</b>							
	17. Father's Name (First, Middle, Last) <b>Carl McCue</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Lantz McCue Campbell</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Orville Evans/husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt 1 Box 281 Horse Shoe Run, WV 26716</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Texas Cemetery</b>		Date <b>9/12/06</b>	20c. Location - City or Town, State <b>Horse Shoe Run, WV</b>						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hinkle Funeral Home, Inc.</b> P.O. Box 186 Davis, WV 26260							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of): <b>Liver Cerebral Hemorrhage.</b> Approximate Interval Between Onset and Death <b>3 days.</b>											
	b. Due to (or as a consequence of):											
	c. Due to (or as a consequence of):											
	d. Due to (or as a consequence of):											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
									<b>M</b>			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) <b>09/28/2006</b>			
	29b. Signature and title of certifier 								29c. License number <b>D23979</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Goralski, MD., 311 N. 4th Street, Oakland, MD</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 29 2006</b>				32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30977

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23 or 28-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1- For State Registrar		1. Decedent's Name (First, Middle, Last) <b>Margaret Louise ENGLISH</b>				2. Date of Death Month Day Year <b>September 17 2006</b>		3. Time of Death p.m. <b>10:35</b>	
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>	
Funeral Director		5. Social Security Number <b>234-12-6005</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>90</b>	If Under 1 Year Months	If Under 24 Hrs. Days	B. Date of Birth (Month, Day, Year) <b>June 10 1916</b>	9. Birthplace (State or Foreign Country) <b>Tennessee</b>	
		Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Washington</b>				10c. City, Town or Location <b>Hagerstown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number <b>12903 The Terrace</b>				10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>USA</b>	
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>0</b>			16b. Kind of Business/Industry <b>Homemaker</b>		
		17. Father's Name (First, Middle, Last) <b>James Washington Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Bradley</b>			
		19a. Informant's Name/Relationship (Type, Print) <b>Jane English - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>937 St. Clair Street, Hagerstown, Md. 21740</b>			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Scott M. Murray</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rose Hill Cemetery</b>	Date <b>9/20/06</b>	20c. Location - City or Town, State <b>Hagerstown, Maryland</b>	
		21. Signature of Funeral Service Licensee <b>Scott M. Murray</b>				22. Name and Address of Facility <b>Minnich Funeral Home</b>	415 E. Wilson Blvd. Hagerstown, Md. 21740		
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>ACUTE BRAINSTEM INFARCTION 18 HOURS</b> <b>Arteriosclerotic Cerebral Artery disease 10 years</b> <b>Hypertension 30 years</b>			
		23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) <b>Sept 18 2006</b>	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Robert Bull MD Personal Physician</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1459 Belmont St. Hagerstown, Md. 21742</b>			
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D 0004359</b>			
		29b. Signature and title of certifier <b>Robert Bull MD Personal Physician</b>				29d. Date signed (Month, Day, Year) <b>Sep 18 2006</b>			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Bull 1459 Belmont St. Hagerstown, Md. 21742</b>				32. Registrar's Signature <b>Robert B. Speaks</b>			
State Registrar		31. Date filed (Month, Day, Year) <b>SEP 19 2006</b>		32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30978

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death			
	Oscar Ely							SEPTEMBER 15, 2006 3:37 PM				
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County of Death				
	Reeders Memorial Home			Boonsboro				Washington				
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 85	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 24, 1921	9. Birthplace (State or Foreign Country) Virginia					
	Usual Residence of Decedent			10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Maryland	Frederick	Frederick										
10e. Street and Number 5643 Singletree Drive				10f. Zip Code 21703			10g. Citizen of What Country? United States					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Welding		16b. Kind of Business/Industry Construction								
17. Father's Name (First, Middle, Last) John Ely				18. Mother's Name (First, Middle, Maiden Surname) Margaret Dean								
19a. Informant's Name/Relationship (Type, Print) Edith Williamson/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5643 Singletree Drive, Frederick, MD 21703								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fee Cemetery		Date	20c. Location - City or Town, State 9/21/2006 Rose Hill, Virginia							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick MD 21702								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Approximate Interval Between Onset and Death 2 months								
<p>a. <i>mass low neck probable malignancy</i> Due to (or as a consequence of):</p> <p>b. <i></i> Due to (or as a consequence of):</p> <p>c. <i></i> Due to (or as a consequence of):</p> <p>d. <i></i></p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Disease Dementia</i> <i>Arterio Sclerotic Cardiovascular Disease</i> <i>Chronic obstructive Pulmonary Disease</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 					29c. License number D 18019			29d. Date signed (Month, Day, Year) SEP 16, 2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vasant Datta 340 Mills Street, Hagerstown, Maryland 21740 301-739-7100				31. Date filed (Month, Day, Year) SEP 18 2006					32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Name: Ely, Oscar  
Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30979  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARVIN R. FISHER, Jr.</b>							2. Date of Death Month Day Year <b>Sept. 16, 2006</b>	3. Time of Death 4:40 a <sup>M</sup>
	4a. Facility Name (If not institution, give street and number) <b>Hartley Hall Nursing Home</b>				4b. City, Town, or Location of Death <b>Pocomoke City</b>			4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>220-32-1581</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>3/25/1934</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>		
	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Worcester</b>				10c. City, Town or Location <b>Pocomoke City</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>2624 Stockton Road</b>				10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>1960 - 1962</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Broker</b>		16b. Kind of Business/Industry <b>Trucking</b>				
	17. Father's Name (First, Middle, Last) <b>Marvin R. Fisher, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Etta Drummond</b>						
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Faye Clayton (cousin)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3841 Church Point Rd., Virginia Beach, VA 23455</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Michael A Dean</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>First Baptist Cemetery</b>		Date <b>9/19/2006</b>	20c. Location - City or Town, State <b>Pocomoke City, MD</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Faye Clayton (cousin)</b>		22. Name and Address of Facility <b>Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Approximate Interval Between Onset and Death <b>7 yrs.</b>						
<p>a. Due to (or as a consequence of): <b>Pulmonary Embolism</b></p> <p>b. Due to (or as a consequence of): <b>Parkinson's disease</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____							
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Bawlf, MD</b>		29c. License number <b>D54422</b>		29d. Date signed (Month, Day, Year) <b>9-16-06</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1604 - Market St., POCOMOKE, MD 21851</b>									
31. Date filed (Month, Day, Year) <b>SEP 18 2006</b>		32. Registrar's Signature <b>John S. Fisher</b>							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BA 101

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30980  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frederick Ray Frye, Sr.</b>						2. Date of Death Month Day Year <b>September 13, 2006</b>	3. Time of Death <b>9:35 PM M</b>
	4a. Facility Name (If not institution, give street and number) <b>3110 St. Peter's Church Road</b>			4b. City, Town, or Location of Death <b>Waldorf</b>			4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>217-42-4998</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Dec. 8, 1944</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Charles</b> 10c. City, Town or Location <b>Waldorf</b>							
	10e. Street and Number <b>3110 St. Peter's Church Road</b>			10f. Zip Code <b>20601</b>			10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Owner/Operator</b>			16b. Kind of Business/Industry <b>Auto Transmissions</b>	
	17. Father's Name (First, Middle, Last) <b>Herman Leon Frye</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Margaret Comer</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Sharon E. Frye - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3110 St. Peter's Church Rd., Waldorf, MD 20601</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>St. Peter's Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>9-18-2006</b>		Date	20c. Location - City or Town, State <b>Waldorf, MD</b>		
	21. Signature of Funeral Service Licensee <b>John Taylor</b>		22. Name and Address of Facility <b>M01391 Huntt Funeral Home</b>		3035 Old Washington RD POB 156, Waldorf, MD 20604			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>BLADDER CARCINOMA</b> Approximate Interval Between Onset and Death <b>18 MTHS.</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>{</b>							
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown							
	23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>DR. NELSON BENJAMIN</b>							
	29c. License number <b>D28281</b>							
	29d. Date signed (Month, Day, Year) <b>September 14, 2006</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NELSON BENJAMIN, MD, 9131 PISCATAWAY ROAD, CLINTON, MD 20735</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>							
	32. Registrar's Signature <b>DR. NELSON BENJAMIN</b>							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

DB12

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30981

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Barbara Reed Feeser		September 13 2006				10:50 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Gilchrist Hospice		Towson				Baltimore	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct 12, 1958	9. Birthplace (State or Foreign Country) Washington DC
216 72 4879							
Usual Residence of Decedent							
10a. State MD	10b. County Howard	10c. City, Town or Location Ellicott City				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9720 Cypressmede Drive		10f. Zip Code 21042		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Warren Kenneth Reed				18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Miller			
19a. Informant's Name/Relationship (Type, Print) David M. Feeser/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9720 Cypressmede Drive Ellicott City, MD 21042					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cem.		Date 9-18-2006	20c. Location - City or Town, State Ellicott City, MD		
21. Signature of Funeral Service Licensee <i>Deon Collier - Witzke</i>		22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043					
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): <i>Melanoma</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 7 years</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>hospice</i>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Barbara Reed Feeser</i>				29c. License number DS8303		29d. Date signed (Month, Day, Year) September 14 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Deon Collier 6601 N Charles St Baltimore MD 21204</i>							
31. Date filed (Month, Day, Year) SEP 18 2006		32. Registrar's Signature <i>Deon Collier</i>					

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006 30982  
Amend Item 3 per verb., G859-09728/06dhb Certificate of Death Reg. No.

1- For State Registrar

<b>Physician /Medical Examiner</b>  <b>Funeral Director</b>  <b>To Be Completed by Funeral Director</b>  <b>To Be Completed by Physician/Medical Examiner</b>  <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>	<p>1. Decedent's Name (First, Middle, Last) <b>CHARLES JESSE GAUMER</b></p> <p>2. Date of Death Month <b>09</b> Day <b>22</b> Year <b>06</b></p> <p>3. Time of Death <b>10:00 AM</b></p> <p>4a. Facility Name (If not institution, give street and number) <b>WMHS Braddock Campus</b></p> <p>4b. City, Town, or Location of Death <b>Cumberland</b></p> <p>4c. County of Death <b>Allegany</b></p> <p>5. Social Security Number <b>220-32-4407</b></p> <p>6. Sex <b>M</b></p> <p>7. Age (In yrs. last birthday) <b>72 Yrs.</b></p> <p>8. Date of Birth (Month, Day, Year) <b>8-15-1934</b></p> <p>9. Birthplace (State or Foreign Country) <b>PA</b></p> <p>10a. State <b>MD</b></p> <p>10b. County <b>ALLEGANY</b></p> <p>10c. City, Town or Location <b>FROSTBURG</b></p> <p>10d. Inside City Limits <b>XX</b></p> <p>10e. Street and Number <b>332 BRADDOCK STREET</b></p> <p>10f. Zip Code <b>21532</b></p> <p>10g. Citizen of What Country? <b>UNITED STATES</b></p> <p>11. Marital Status <b>Married</b></p> <p>12. Was Decedent Ever in U.S. Armed Forces? <b>Yes</b></p> <p>If Yes, Give Year or Dates: <b>1953-1956</b></p> <p>13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>No</b></p> <p>If Yes, specify Cuban, Mexican, Puerto Rican, etc. <b>Specify: WHITE</b></p> <p>14. Race - American Indian, Black, White, etc. <b>Specify: WHITE</b></p> <p>15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b></p> <p>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PLUMBER/PIPEFITTER</b></p> <p>16b. Kind of Business/Industry <b>PLUMBING</b></p> <p>17. Father's Name (First, Middle, Last) <b>HARVEY M. GAUMER</b></p> <p>18. Mother's Name (First, Middle, Maiden Surname) <b>MEREDIETH WILLISON YATES GAUMER</b></p> <p>19a. Informant's Name/Relationship (Type, Print) <b>SARAH JEAN GAUMER/wife</b></p> <p>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>332 BRADDOCK STREET FROSTBURG, MD 21532</b></p> <p>20a. Method of Disposition <b>Burial</b></p> <p>20b. Place of Disposition (Name of cemetery, crematory or other place) <b>VALE SUMMIT CEMETERY</b></p> <p>Date <b>9/24/2006</b></p> <p>20c. Location - City or Town, State <b>FROSTBURG MD</b></p> <p>21. Signature of Funeral Service Licensee <b>Alan M. Sowers moogy7</b></p> <p>22. Name and Address of Facility <b>SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532</b></p> <p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>END STAGE MULTIPLE SCLEROSIS</b></p> <p>Approximate Interval Between Onset and Death <b>&gt;10 years</b></p> <p>23b. Was decedent pregnant in the past 12 months? <b>Yes</b></p> <p>23c. If yes, outcome of pregnancy <b>Live birth</b></p> <p>23d. Date of delivery <b>Month Day Year</b></p> <p>23e. Did tobacco use contribute to the cause of death? <b>Yes</b></p> <p>23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    </p> <p>23g. Did tobacco use contribute to the cause of death? <b>Yes</b></p> <p>23h. Was an autopsy performed? <b>Yes</b></p> <p>23i. Were autopsy findings available prior to completion of cause of death? <b>Yes</b></p> <p>25. Was case referred to medical examiner? <b>No</b></p> <p>26. Place of Death (Check only one) <b>Hospital</b></p> <p>27. Manner of Death <b>Natural</b></p> <p>28a. Date of Injury (Month, Day, Year) <b>MD</b></p> <p>28b. Time of Injury <b>1 Yes 2 No</b></p> <p>28c. Injury at Work? <b>Yes</b></p> <p>28d. Describe how injury occurred    </p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)    </p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)    </p> <p>29a. Certifier (Check only one) <b>Certifying Physician</b></p> <p>29b. Signature and title of certifier <b>Dr Qamar Zaman</b></p> <p>29c. License number <b>D0023371</b></p> <p>29d. Date signed (Month, Day, Year) <b>SEPT, 22, 2006</b></p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr Qamar Zaman 625 Kent Avenue Cumberland MD 21502</b></p> <p>31. Date filed (Month, Day, Year) <b>SEP 29 2006</b></p> <p>32. Registrar's Signature <b>Leanne A. Jones</b></p>						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30983  
Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Louise E. Green</b>							2. Date of Death Month Day Year <b>September 11, 2006</b>	3. Time of Death <b>5:10 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Independent Court Nursing Home</b>			4b. City, Town, or Location of Death <b>Hyattsville</b>			4c. County of Death <b>Prince George</b>			
Funeral Director	5. Social Security Number <b>215-44-7997</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) <b>Mar. 10, 1918</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Anne Arundel</b> 10c. City, Town or Location <b>Severn</b>									10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>311 Buskin Court</b>			10f. Zip Code <b>21114</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Year or Dates:</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Specify: White</b>			14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>College (1-4 or 5+)</b> <b>2</b> <b>Office Supervisor</b>		16b. Kind of Business/Industry <b>District Government</b>					
	17. Father's Name (First, Middle, Last) <b>Herman B. Earp</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Martin</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Eugene Green/Son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>311 Buskin Court, Severn, MD 21114</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>► Altha Miller</b>			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		Date <b>9/19/2006</b>	20c. Location - City or Town, State <b>Brentwood, MD</b>			
	21. Signature of Funeral Service Licensee <b>Altha Miller</b>			22. Name and Address of Facility <b>Fort Lincoln Funeral Home</b> <b>3401 Bladensburg Road Brentwood, MD 20722</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Dementia</b> Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Cerebro Vascular disease</b>								Approximate Interval Between Onset and Death <b>7 years</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <b>► Maria Farooqui, M.D.</b>								29c. License number <b>MD 33052</b>	29d. Date signed (Month, Day, Year) <b>8-2-06</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Maria Farooqui, M.D. 1160 Varnum St., N.E. Washington, DC 20017</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>		32. Registrar's Signature <b>► Maria Farooqui</b>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30984

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	Virginia Maye Gibney							September 15 2006	10:15 PM
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death	
	Washington County Hospital				Hagerstown, Maryland			Washington	
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sept 18, 1920	9. Birthplace (State or Foreign Country) Pennsylvania	
	214-09-6171								
Usual Residence of Decedent									
10a. State	10b. County		10c. City, Town or Location						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Maryland	Washington		Hagerstown						
10e. Street and Number 232 Bryan Place				10f. Zip Code 21740				10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Domestic	
17. Father's Name (First, Middle, Last) Paul Stickell Gluck					18. Mother's Name (First, Middle, Maiden Surname) Mary Maye Rinedollar				
19a. Informant's Name/Relationship (Type, Print) Gregory Gibney / Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Hollymead Terrace Hagerstown Maryland 21742				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Spring Grove Cemetery			Date 9/20/2006	20c. Location - City or Town, State Lemasters, Pennsylvania
21. Signature of Funeral Service License 					22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): Intra abdominal bleed Due to (or as a consequence of): Kidney disease Cerebral Due to (or as a consequence of):									
Approximate Interval Between Onset and Death 1 week 2 week 2 week									
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
M									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 									
29c. License number D283 65									
29d. Date signed (Month, Day, Year) 9-17-06									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maye Gibney 368 Mill Street Hagerstown MD 21740									
31. Date filed (Month, Day, Year) SEP 19 2006		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

✓ To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 ✓ To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For  
State  
Registrar

Amend Items 25,27,28a-f per ME G860 10/04/06dhb

State of Maryland / Department of Health and Mental Hygiene

2006 30985

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	Judy Lee Goins							September 15 2006	1010 P M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	Washington County Hospital			Hagerstown			Washington		
Usual Residence of Decedent		10a. State	10b. County	10c. City, Town or Location			10d. Inside City Limits		
		Maryland	Washington	Hagerstown			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?				
11 W. Baltimore Street - Apt. 108		21740			USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 10		College (1-4 or 5+) 0			None			None	
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)					
Ellis Lee Goins				Margaret Haskins					
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Kenneth W. Goins - Husband				11 W. Baltimore St., Hagerstown, Md. 21740					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State			
Hagerstown Crematory		9/19/06			Hagerstown, Maryland				
21. Signature of Funeral Service Licensee <i>Scott Mummolo</i>		22. Name and Address of Facility			Minnich Funeral Home				
		415 E. Wilson Blvd., Hagerstown, Md. 21740							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. Due to (or as a consequence of): <i>Small bowel obstruction</i>			Approximate Interval Between Onset and Death <i>0 DAYS</i>				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of): <i>End stage renal disease</i>			YEARS				
		c. Due to (or as a consequence of): <i>Gastrointestinal bleed</i>			DAYS				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)			23d. Date of delivery Month Day Year				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one)			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
27. Manner of death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
		28a. Date of Injury (Month, Day, Year) <i>Unknown</i>			28b. Time of Injury <i>Unknown M</i>			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred <i>Subject was in a motor vehicle accident</i>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>9/17/06</i>			29c. License number <i>D0862223</i>			29d. Date signed (Month, Day, Year) <i>9/17/06</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
PLAYER BOLAN UM, MD		340, MILL STREET, HAGERSTOWN, MD 21740							
31. Date filed (Month, Day, Year) <i>SEP 19 2006</i>		32. Registrar's Signature <i>Patricia B. Spurlock</i>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



**Please Type or Print in Black Indelible Ink**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg No.

2006 30987

**1. For State Registrar****Physician/  
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

John Wade Guassardo

2. Date of Death

Month Day Year  
September 12, 20063. Time of Death  
2045 hrs**Funeral Director**

4a. Facility Name (if not institution, give street and number)

I-70 West at mile marker 31

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

6. Sex

7. Age (In yrs. last birthday)

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

9. Birthplace (State or Foreign Country)

217-17-1258

1  M2  F

23

Yrs.

Months

Days

Hours

Min.

Dec. 26, 1982

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1  Yes 2  No

10e. Street and Number

7040 Hames Court

10f. Zip Code

21703

10g. Citizen of What Country?

United States

11. Marital Status

1  Never Married 2  Married3  Widowed 4  Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1  Yes 2  No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1  Yes 2  No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Industrial

17. Father's Name (First, Middle, Last)

Mark W. Guassardo

18 Mother's Name (First, Middle, Maiden Surname)

Linda Himerman

19a. Informant's Name/Relationship (Type, Print)

Linda Guassardo / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7040 Hames Court, Frederick, MD 21702

20a. Method of Disposition

1  Burial 2  Cremation 3  Removal from State4  Donation 5  Other Specify

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Prospect Cemetery

Date

9/18/2006

20c. Location - City or Town, State

Mt. Airy, Maryland

21. Signature of Funeral Service Licensee

Courtney Stauffer

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED item#1, perME,g860, 10/12/06 TT

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1  Yes 2  No 9  Unknown

23c. If yes, outcome of pregnancy

1  Live birth 2  Fetal death 3  Ectopic pregnancy4  Pregnant at time of death 5  Other (Specify)9  Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death?

1  Yes 2  No 3  Probably 4  Unknown

24a. Was an autopsy performed?

1  Yes 2  No

24b. Were autopsy findings available prior to completion of cause of death?

1  Yes 2  No

25. Was case referred to medical examiner?

1  Yes 2  No

Hospital:

1  Inpatient 2  ER/Outpatient 3  DOA4  Nursing Home 5  Residence 6  Other Scene

27. Manner of Death

1  Natural5  Pending Investigation2  Accident6  Could not be determined3  Suicide7  Homicide4  Homicide

28a. Date of Injury (Month, Day, Year)

Sep 12, 2006

28b. Time of Injury

2032 hrs

28c. Injury at Work?

1  Yes 2  No

28d. Describe how injury occurred

Driver of vehicle went off road, ejected and struck by other cars

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Interstate/Express

28f. Location (Street and Number or Rural Route Number, City or Town, State)

I-70 West at mile marker 33, Hagerstown, MD

29a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

Zabiullah Ali, M.D.

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 13, 2006

31. Date filed (Month, Day, Year)

SEP 18 2006

32. Registrar's Signature

Zabiullah Ali

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2006 30988  
Reg. No.

For  
State  
Registrar

1-

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) <b>Elsworth Robert Goode</b>				2. Date of Death Month Day Year <b>September 14 2006</b>	3. Time of Death 11:45 PM	
Funeral Director		4a. Facility Name (If not institution, give street and number) <b>Frederick Villa Nursing Home</b>				4b. City, Town, or Location of Death <b>Catonsville</b>	4c. County of Death <b>Baltimore</b>	
To Be Completed by Funeral Director		5. Social Security Number <b>216 34 0711</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>69 Yrs.</b>	If Under 1 Year Months Days Hours Min. If Yes, Give Year or Dates: <b>1956-60</b>	8. Date of Birth (Month, Day, Year) <b>June 17, 1937</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
		Usual Residence of Decedent 10a. State <b>MD</b>				10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Woodlawn</b>	10d. Inside City Limits 1 □ Yes <b>2 X No</b>
		10e. Street and Number <b>5910 Saint Mary's St.</b>				10f. Zip Code <b>21207</b>	10g. Citizen of What Country? <b>United States</b>	
		11. Marital Status 1 □ Never Married <b>2 X Married</b> 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes <b>2 X No</b> If Yes, Give Year or Dates: <b>1956-60</b>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes <b>2 X No</b> Specify: <b>White</b>	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <b>Meat Cutter</b>	16b. Kind of Business/Industry <b>Grocery</b>				
		17. Father's Name (First, Middle, Last) <b>Arthur Lenuel Goode</b>	18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Frances Martin</b>					
		19a. Informant's Name/Relationship (Type, Print) <b>Donna Marie Goode/Wife</b>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5910 Saint Mary's St. Woodlawn, MD 21207</b>					
Physician /Medical Examiner		20a. Method of Disposition 1 □ Burial <b>2 X Cremation</b> 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) <i>None</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>	Date <b>9-19-2006</b>	20c. Location - City or Town, State <b>Catonsville, MD</b>			
Medical Certification: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <i>None</i>	M01044	22. Name and Address of Facility <b>Harry H. Witzke's Family FH Inc.</b> <b>4112 Old Columbia Pike Ellicott City, MD 21043</b>				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>Three days.</b>		
		a. <b>Broncho-pneumonia</b> Due to (or as a consequence of):				Years. <b>Years.</b>		
		b. <b>Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of):						
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes <b>2 X No</b> 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth <b>2 □ Fetal death</b> 3 □ Ectopic pregnancy 4 □ Pregnant at time of death <b>5 □ Other (specify)</b> 9 □ Unknown	23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Peripheral Vascular Disease</b> <b>Non Insulin Dependant Diabetes Mellitus</b>				23e. Did tobacco use contribute to the cause of death? 1 □ Yes <b>2 X No</b> 3 □ Probably 4 □ Unknown		
		25. Was case referred to medical examiner? 1 □ Yes <b>2 X No</b>	26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)					
		27. Manner of Death 1 □ Natural <b>2 □ Accident</b> 3 □ Suicide 4 □ Homicide	28a. Date of Injury (Month, Day Year) <b>5 □ Pending investigation</b>	28b. Time of Injury M <b>1 □ Yes 2 □ No</b>	28c. Injury at Work? 1 □ Yes <b>2 □ No</b>	28d. Describe how injury occurred		
		6 □ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>N B Vellanki, MD; 8850 Columbia 100 Parkway, #Suite 308, Columbia, MD 21046.</b>	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>	29c. License number <b>D 30469.</b>					
		29b. Signature and title of certifier <i>N B Vellanki</i>	29d. Date signed (Month, Day, Year) <b>Sept. 15, 2006</b>					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N B Vellanki, MD; 8850 Columbia 100 Parkway, #Suite 308, Columbia, MD 21046.</b>	31. Date filed (Month, Day, Year) <b>SEP 18 2006</b>					
		32. Registrar's Signature <i>None</i>						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30989  
Reg. No.1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Blanche Henry</b>							2. Date of Death Month <b>9</b> Day <b>10</b> Year <b>06</b>	3. Time of Death <b>3:30pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>			4b. City, Town, or Location of Death <b>Laurel</b>			4c. County of Death <b>Prince George's</b>			
Funeral Director	5. Social Security Number <b>220-26-6441</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>July 28, 1929</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Upper Marlboro</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number <b>128 Queen Anne Bridge Rd.</b>			10f. Zip Code <b>20774</b>			10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates: <b>8th</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bus Aide</b>			16b. Kind of Business/Industry <b>P.G. County Schools</b>			
	17. Father's Name (First, Middle, Last) <b>Harry B. Watkins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cora Watson</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Hugh James Henry / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>128 Queen Anne Bridge Rd. Upper Marlboro, MD 20774</b>					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Resurrection Cemetery</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		Date <b>9/18/06</b>	20c. Location - City or Town, State <b>Clinton, MD</b>		
Medical Certifier: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Juanita D. Pridgen</b>				22. Name and Address of Facility <b>BEALL Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>5 days</b>		
	<p>a. Due to (or as a consequence of): <b>Sepsis</b></p> <p>b. Due to (or as a consequence of): <b>Renal insufficiency</b></p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>							Unknown		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus, CVA</b> <b>HTN</b>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29c. License number <b>D0060643</b>		
	29b. Signature and title of certifier <b>FARIA FARHAT M.D.</b>							29d. Date signed (Month, Day, Year) <b>9/10/06</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FARIA FARHAT 7300 Vandusen Rd Laurel, MD 20707</b>									
	31. Date filed (Month, Day, Year) <b>SEP 14 2006</b>				32. Registrar's Signature <b>FARIA FARHAT</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

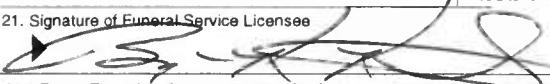
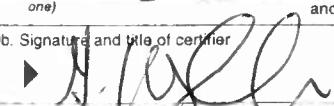
State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30990

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alfred William Henson, Jr.</b>							2. Date of Death Month Sept. Day 18 Year 2006	3. Time of Death 5:50 A M	
	4a. Facility Name (If not institution, give street and number) <b>348 S. Cannon Avenue</b>			4b. City, Town, or Location of Death <b>Hagerstown</b>			4c. County of Death <b>Washington</b>			
Funeral Director	5. Social Security Number <b>220-09-9098</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87 Yrs.</b>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <b>01/05/1919</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Washington</b> 10c. City, Town or Location <b>Hagerstown</b>								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>247 N. Mulberry Street</b>			10f. Zip Code <b>21740</b>			10g. Citizen of What Country? <b>US</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>			16b. Kind of Business/Industry <b>Trucking</b>			
	17. Father's Name (First, Middle, Last) <b>Alfred William Henson, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Amanda Nave</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Roseanna Brewer / Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>310 Bently Ct., Hagerstown, MD 21740</b>			Date <b>9/21/2006</b>	20c. Location - City or Town, State <b>Hagerstown, MD</b>		
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>			21. Signature of Funeral Service Licensee 			
							22. Name and Address of Facility <b>Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>4 days</b>	
	<p>a. <b>Cerebral Vascular Accident</b> Due to (or as a consequence of):</p> <p>b. <b>Congestive Heart Failure</b> Due to (or as a consequence of):</p> <p>c. <b>Diabetes</b> Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Daughter Home</b>	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <b>D0057285</b>							
	29b. Signature and title of certifier 								29d. Date signed (Month, Day, Year) <b>9/18/2006</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>G. Koilillai, MD, 24 N. Walnut St., #102, Hagerstown, MD 21740</b>									
	31. Date filed (Month, Day, Year) <b>SEP 20 2006</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2006 30991

For  
State  
Registrar

Physician

/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Lorie Marie Hutton</b>		2. Date of Death Month <b>September</b> Day <b>12</b> Year <b>2006</b>		3. Time of Death <b>0355AM</b>
4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY SPECIALTY HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death
5. Social Security Number <b>214-80-0883</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>36 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month Day Year) <b>March 20, 1970</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Montgomery Village</b>
10e. Street and Number <b>9206 Broadwater Drive</b>		10f. Zip Code <b>20886</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operation Manager</b>		16b. Kind of Business/Industry <b>Henry Jackson Foundation Government Contractor</b>
17. Father's Name (First, Middle, Last) <b>Unknown Emmans</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Peggy Duncan</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Keith E. Hutton/ Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9206 Broadwater Drive, Montgomery Village, MD 20886</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Gate of Heaven Cemetery</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>Sept. 20, 2006</b>
21. Signature of Funeral Service Licensee <b>Andrew J Cole</b>		22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901</b>		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. <b>Cardiomyopathy</b> Due to (or as a consequence of):</p> <p>b. <b>Renal failure</b> Due to (or as a consequence of):</p> <p>c. <b>Encephalopathy</b> Due to (or as a consequence of):</p> <p>d. <b>Seizure disorder</b></p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>Charu Mehta, MD</b>		29c. License number <b>D 34974</b>		29d. Date signed (Month, Day, Year) <b>Sept 12<sup>th</sup>, 2006</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHARU MEHTA, MD 601, South Charles Street, MD 21230</b>				
31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>		32. Registrar's Signature <b>New B. Smith</b>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30992

Certificate of Death

Reg. No.

1- For  
State  
Registrar

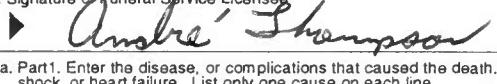
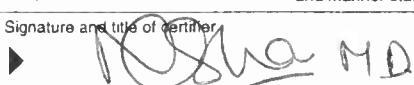
Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 23c-f show any injury, other than traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	Anne Dillard Hager				2. Date of Death Month Day Year	3. Time of Death	
Crescent Cities Center				Riverdale	Sept. 9, 2006	10:45AM	
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				4c. County of Death		
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
577-12-1628		88 Yrs.		Apr. 4, 1918	Alabama		
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
D.C.	N/A	Washington					
10e. Street and Number	10f. Zip Code			10g. Citizen of What Country?			
426 Jefferson Street, N.W.	20011			United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
Elementary/Secondary (0-12)	College (1-4 or 5+) 3	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
				HUD - Inspector			
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)			
Alex Cunningham				Annie N. Dillard			
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Alida Hager-Matthews (daughter)				426 Jefferson St. N.W., Wash. D.C. 20011			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
		Gate of Heaven		9/22/06		Silver Spring, MD	
21. Signature of Funeral Service Licensee 							
22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 20012							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
a. Sepsis Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. (Blank)							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Atrial Fibrillation, Coronary Artery Disease							
Congestive Heart Failure, Large Pleural Effusion							
23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> No							
23g. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
23h. Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
23i. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
23j. Date of Injury (Month, Day, Year) 23k. Time of Injury M 23l. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 23m. Describe how injury occurred							
23n. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
23o. Location (Street and Number or Rural Route Number, City or Town, State)							
23p. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
23q. Signature and title of Certifier 							
23r. License number D48213							
23s. Date signed (Month, Day, Year) 09-11-2006							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neelam Ashai, M.D. 4410 74th Avenue, Landover Hills, MD 20784							
31. Date filed (Month, Day, Year) SEP 15 2006							
32. Registrar's Signature 							

ORIGINAL

State  
Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

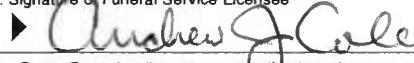
State of Maryland / Department of Health and Mental Hygiene

2006 30993

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Donald Robert Harris</b>							2. Date of Death Month Day Year <b>September 11, 2006</b>	3. Time of Death <b>2:30 p m</b>	
	4a. Facility Name (If not institution, give street and number) <b>Wilson Health Care At Asbury Village</b>			4b. City, Town, or Location of Death <b>Gaithersburg</b>			4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>579-36-1650</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75 Yrs.</b>	If Under 1 Year Months <b>0</b>	If Under 24 Hrs. Days <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Dec. 25, 1930</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	10a. State <b>Maryland</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Wheaton</b>							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2816 Parker Avenue</b>				10f. Zip Code <b>20902</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>Korean Conflict</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Letter Carrier</b>		16b. Kind of Business/Industry <b>Government</b>						
17. Father's Name (First, Middle, Last) <b>Francis Dorsey Harris</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel M'liiss Leizear</b>						
19a. Informant's Name/Relationship (Type, Print) <b>D. Robert Harris/ Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>114 Apple Blossom Way, Gaithersburg, MD 20878</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Burtonsville Union Cemetery</b>			Date <b>Sept. 15, 2006</b>	20c. Location - City or Town, State <b>Burtonsville, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death	
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Cancer of Lung with Metastasis</b> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Failure to Thrive, Osteoporosis</b>									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
									28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29c. License number <b>319609</b>	29d. Date signed (Month, Day, Year) <b>9.14.06</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Raman Tuli, M.d 10810 Darnestown Road, 3202, Gaithersburg, MD 20878</b>										
31. Date filed (Month, Day, Year) <b>SEP 15 2006</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30994

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		Beverly Hauss		2. Date of Death Month Day Year	3. Time of Death
				September 13, 2006 5:20 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Casey House Montgomery Hospice		Rockville		Montgomery	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
577-38-4397					8. Date of Birth (Month, Day, Year) Oct. 30, 1926
9. Birthplace (State or Foreign Country) Washington, DC					
Usual Residence of Decedent					
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 10109 Renfrew Road		10f. Zip Code 20901		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white	
14. Race - American Indian, Black, White, etc.					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Legal Secretary		16b. Kind of Business/Industry Radio Communications Firm	
17. Father's Name (First, Middle, Last) William Dobkin		18. Mother's Name (First, Middle, Maiden Surname) Bessie E. Horowitz			
19a. Informant's Name/Relationship (Type, Print) Patricia Coggeshall, Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4102 Denfeld Ave., Kensington, MD 20895			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Gardens		Date 09/17/06	20c. Location - City or Town, State Olney, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death  <i>metastatic peritoneal cancer</i>			
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice House			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred House
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number H0058032		29d. Date signed (Month, Day, Year) Sept. 14, 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D.O., 6001 Muncaster Mill Road, Rockville, MD 20855					
31. Date filed (Month, Day, Year) SEP 15 2006		32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2006 30995

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Jane Cowan Hunt		September 11 2006				2:15 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Doctors Community Hospital		Lanham				Prince George's	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 8, 1914	9. Birthplace (State or Foreign Country) Georgia
Usual Residence of Decedent		10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Mitchellville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 10450 Lottsford Road, #3-46		10f. Zip Code 20721				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1-4 Assistant Manager		16b. Kind of Business/Industry Beltsville Agriculture Research Ctr. Credit Union			
17. Father's Name (First, Middle, Last) Jack		18. Mother's Name (First, Middle, Maiden Surname) Cowan Jessie (unk)					
19a. Informant's Name/Relationship (Type, Print) Brian E. Hunt -son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1717 Kensington Place The Villages, FL 32162					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 9/16/2006		20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Donald V. Borwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705					
23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a.  Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number Cielito M. Aquinaldo, M.D. D 41945					
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 09/12/06					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane Lang MD 20714							
31. Date filed (Month, Day, Year) SEP 15 2006		32. Registrar's Signature 					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2006 30996

Reg. No.

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Paul Merrill Johnson</b>						2. Date of Death Month Day Year <b>September 14, 2006</b>	3. Time of Death 0018 a <sup>M</sup>
	4a. Facility Name (If not institution, give street and number) <b>UMHS-Braddock Campus</b>			4b. City, Town, or Location of Death <b>Cumberland</b>			4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>234-62-4447</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>May 14, 1940</b>	9. Birthplace (State or Foreign Country) <b>New York</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>MD</b> 10b. County <b>Garrett</b> 10c. City, Town or Location <b>Grantsville</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>891 Dorsey Hotel Road, Rm 223</b>			10f. Zip Code <b>21536</b>			10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1960-1962</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Communications</b>			16b. Kind of Business/Industry <b>Satelite Research</b>	
	17. Father's Name (First, Middle, Last) <b>Merrill Johnson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret McMahon</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Carl Johnson, Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10211 Day Avenue, Silver Springs, MD 20910</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Grove Cemetery</b>			Date <b>9/17/06</b>	20c. Location - City or Town, State <b>Oakland, MD</b>	
	21. Signature of Funeral Service Licensee <b>Katherine Switzer</b>			22. Name and Address of Facility <b>Burdock-Durst Funeral Home 21 N. Second St., Oakland, MD 21550</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Severe chronic obstructive Lung Disease</b> Approximate Interval Between Onset and Death <b>6 months</b>							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)							
	23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) <b>Sept 14, 2006</b> 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Wonsok Shin M.D.</b> 29c. License number <b>D0055325</b> 29d. Date signed (Month, Day, Year) <b>Sep 14, 2006.</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WONSOCK SHIN 48 Tarn Terrace Frostburg MD 21532</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 20 2006</b>		32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30997

1- For  
State  
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death
	Meyer Kushner						September 11, 2006	8:45 PM

Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
	Hebrew Home of Greater Washington			Rockville			Montgomery	

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) November 29, 1915	9. Birthplace (State or Foreign Country) Maryland
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Usual Residence of Decedent							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Rockville					

10e. Street and Number 6121 Montrose Road			10f. Zip Code 20852	10g. Citizen of What Country? U.S.A.			
--	--	--	------------------------	---	--	--	--

11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
---	--	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Entrepreneur	16b. Kind of Business/Industry Advertising
--	--	--	---

17. Father's Name (First, Middle, Last) Hyman Kushner			18. Mother's Name (First, Middle, Maiden Surname) Rebecca Berman
--	--	--	---

19a. Informant's Name/Relationship (Type, Print) Linda Millikin - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Fox Trail Terrace, Gaithersburg, Maryland 20878		
---	--	--	--	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) King David Memorial Gardens	Date 9/14/2006	20c. Location - City or Town, State Falls Church, Virginia
---	---	-------------------	---

21. Signature of Funeral Service Licensee ► Nancy A. Recante	22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	23b. Due to (or as a consequence of): Inanition	Approximate Interval Between Onset and Death two weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): lung carcinoma	two years
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
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<i>Chronic obstructive pulmonary disease</i> <i>gastrointestinal bleeding</i>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
--	--	--	--

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
---	--

27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
---	---------------------------------------	---------------------	--	-----------------------------------

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number MD 30946	29d. Date signed (Month, Day, Year) 09 12 2006
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29b. Signature and title of certifier <i>Kris E. Kushner, M.D.</i>	32. Registrar's Signature <i>Rebecca B. Aspinwall</i>
---	--

31. Date filed (Month, Day, Year) SEP 15 2006	32. Registrar's Signature
--	---------------------------

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

**Certificate of Death**

2006 30998  
Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

Usual Residence of Decedent  
10a. State Maryland 10b. County Prince George's  
10c. City, Town or Location Greenbelt  
10d. Inside City Limits 1  Yes 2  No

Department: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury, or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death
<i>MARTHA KROFCHTIK</i>					4:47 PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				4c. County of Death
<i>Renaissance Gardens @ Riderwood Village</i>					<i>Silver Spring</i>
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month Day Year)	9. Birthplace (State or Foreign Country) Pennsylvania
109-16-9369		83 Yrs.		Sept. 25, 1922	
10a. State	10b. County	10c. City, Town or Location			10d. Inside City Limits
Maryland	Prince George's	Greenbelt			1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number	10f. Zip Code			10g. Citizen of What Country?	
6 Fayette Place	20770			United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
Elementary/Secondary (0-12) 12	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry own home
17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)				
Walter	Krsiak			Pauline Pecnik	
19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Suzanne Krofcik -daughter	6 Fayette Place Greenbelt, Maryland 20770				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State	
	Arlington National Cemetery		9/20/2006	Arlington, Virginia	
21. Signature of Funeral Service Licensee <i>K. R. Shum</i>	22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): <i>Thrombocytopenic purpura</i>	b. Due to (or as a consequence of): <i>Heart disease</i>	c. Due to (or as a consequence of): <i>Severe anemia</i>	d. Due to (or as a consequence of): <i>Shock</i>	Approximate Interval Between Onset and Death 2 weeks
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one)	29b. Signature and title of certifier <i>Karen J. Merritt</i>				
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D0043375				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29d. Date signed (Month, Day, Year) 9/12/06				
31. Date filed (Month, Day, Year) SEP 15 2006	32. Registrar's Signature <i>Karen J. Merritt, M.D.</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 30999

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ellen Patricia Kraemer	September 13, 2006	9:38 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
3220 Ludham Drive	Silver Spring	Montgomery			
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 22, 1932	9. Birthplace (State or Foreign Country) New Jersey
147-24-9096		74			

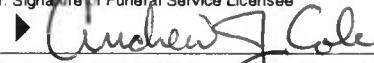
To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Usual Residence of Decedent	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 3220 Ludham Drive	10f. Zip Code 20906	10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attendance Secretary	16b. Kind of Business/Industry Education		
17. Father's Name (First, Middle, Last) James T. White	18. Mother's Name (First, Middle, Maiden Surname) Helen T. Drury			
19a. Informant's Name/Relationship (Type, Print) Gustave H. Kraemer/ Husband	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3220 Ludham Drive, Silver Spring, MD 20906			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery	Date Sept. 15, 2006	20c. Location - City or Town, State Silver Spring, Maryland	
21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901			

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death 4 Years	
a. Emphysema Due to (or as a consequence of):		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number d23630	29d. Date signed (Month, Day, Year) September 14, 2006
29b. Signature and title of certifier 		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Frank Mayo	16220 Frederick Road, #213, Gaithersburg, Md 20877	
31. Date filed (Month, Day, Year) SEP 15 2006	32. Registrar's Signature 	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 006 31000

Certificate of Death

Reg. No.

1- For  
State  
Registrar

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or item 23a or 26a-1 show any injury or other traumatic event. The Medical Examiner must be notified at D.O.C.S.

Kenneth Roger Kooken

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Kenneth Roger Kooken		September 17 2006				1145 AM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Memorial Hospital at EASTON		EASTON				Talbot	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 14, 1914	9. Birthplace (State or Foreign Country) West Virginia
10a. State MD.		10b. County Garrett		10c. City, Town or Location Bloomington			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 351 North Branch Ave.		10f. Zip Code 21523				10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No WW 2 If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Paper Maker				16b. Kind of Business/Industry Paper Manufacturer	
17. Father's Name (First, Middle, Last) Alfred Lewis Kooken		18. Mother's Name (First, Middle, Maiden Surname) Edna Ours					
19a. Informant's Name/Relationship (Type, Print) Janet Fazenbaker/ daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13149 Greensboro Rd., Greensboro, Maryland 21639					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Queens Point Cemetery		Date 09/20/2006	20c. Location - City or Town, State Keyser, West Virginia		
21. Signature of Funeral Service Licensee ► F. Wayne Boal		22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, try leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death	
a. Aspiration Pneumonia Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
1) congestive heart failure 2) Acute Renal Failure						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier ► Dr. Dennis DeShields		29c. License number 0005310				29d. Date signed (Month, Day, Year) September 18, 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Dennis DeShields 219 S. Washington St., Easton, Md., 21601							
31. Date filed (Month, Day, Year) SEP 20 2006		32. Registrar's Signature Nancy A. DeShields					

ORIGINAL